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PROPOSED PAHO STRATEGIC PLAN 2014-2019

DRAFT PAHO STRATEGIC PLAN 2014-2019

"Championing Health: Sustainable Development and Equity"

DRAFT FOR EXECUTIVE COMMITTEE AND NATIONAL CONSULTATIONS

June 2013

Introductory Note for the Executive Committee

1. In accordance with the road map for developing the Strategic Plan (SP) 2014-2019 and Program and Budget (PB) 2014-2015 of the Pan American Health Organization (PAHO), as approved by the 151st Session of the Executive Committee of PAHO in September 2012, the SP 2014-2019 is being developed in three phases aligned with PAHO's Governing Bodies cycle for 2013, as follows:

(a) *Phase 1:* Present a draft to the Seventh Session of the Subcommittee on Program, Budget, and Administration (SPBA7) in March 2013, taking into consideration the decisions made by the Executive Board of the World Health Organization (WHO) in January 2013 regarding WHO's draft 12th General Programme of Work (GPW) 2014-2019;

(b) *Phase 2:* Draft the SP 2014-2019 and submit the document for consideration by the 152nd Session of the Executive Committee of PAHO in June 2013, by which point it will have been strengthened by input from *the* final version of WHO's 12th GPW as well as WHO's PB 2014-2015, as approved by the World Health Assembly in May 2013; and

(c) *Phase 3:* Present the final proposed SP 2014-2019 for approval by PAHO's 52nd Directing Council in September 2013.

2. To ensure the involvement of PAHO Member States and their ownership in the development of PAHO's SP 2014-2019, in addition to the mechanisms established by its Governing Bodies, PAHO's Executive Committee appointed a Member States Countries Consultative Group (CCG). This Group was assigned responsibility for providing strategic and technical input in the crafting of the SP 2014-2019 and its first PB 2014-2015.

3. In light of the ongoing dialogue with Member States regarding WHO's programmatic reform, particularly its 12th GPW and PB 2014-2015, as well as its influence on PAHO's planning frameworks and processes, this proposed draft is presented to the Executive Committee as a working document. This draft which may be adjusted based on the final WHO GPW and PB approved by the 66th World Health Assembly in May 2013.

4. This document has benefitted from review and input by the CCG. The Pan American Sanitary Bureau (PASB) will continue to develop the SP 2014-2019 with the full participation of PAHO Member States, as well as PASB staff at all levels, to ensure that a comprehensive document is submitted to the 52nd Directing Council of PAHO in September 2013 for its approval.

PASB welcomes input and recommendations from Executive Committee Member States on the draft document, which will enable it to move forward in completing the full SP 2014-2019.

DRAFT PAHO STRATEGIC PLAN 2014-2019

"Championing Health: Sustainable Development and Equity"

Pan American Health Organization
Regional Office of the World Health Organization

June 2013

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PAHO STRATEGIC PLAN 2014-2019

I. Foreword by the Director

[TO BE COMPLETED]

II. Executive Summary

[TO BE COMPLETED]

III. Introduction

1. The Pan American Health Organization (PAHO) Strategic Plan ("the Plan") is the Organization's highest-level planning instrument, as approved by its Governing Bodies. The Plan sets out the Organization's strategic direction, based on its Member States' collective priorities, and specifies the results to be achieved during the planning period. The Plan also establishes the commitment made by the PAHO Member States and the Pan American Sanitary Bureau (PASB), thus serving as the basis for developing the biennial Program and Budgets to implement the Plan. The Plan is a product of collaboration and consultation with Member States and incorporates contributions of staff at all levels of the PASB.

2. The PAHO Strategic Plan 2014-2019 (SP 2014-2019) responds to both regional and global mandates. As a result, the Plan's strategic agenda represents a balance between PAHO's response to the regional priorities established in the Health Agenda for the Americas 2008-2017, other regional mandates set by PAHO Member States, the collective national priorities identified in analyses of PAHO's Country Cooperation Strategies (CCSs), and the programmatic alignment with the General Programme of Work (GPW) of the World Health Organization (WHO). The plan is also consistent with the parameters of the main intergovernmental agreements for development operations of the United Nations (UN) system. The development and implementation of the Plan are guided by PAHO's vision, mission, values, and core functions. The Plan will lay down the framework for championing health, sustainable development, and equity. The plan will seek to achieve universal health coverage and to incorporate the determinants of health as an all-encompassing theme that cuts across all its components.

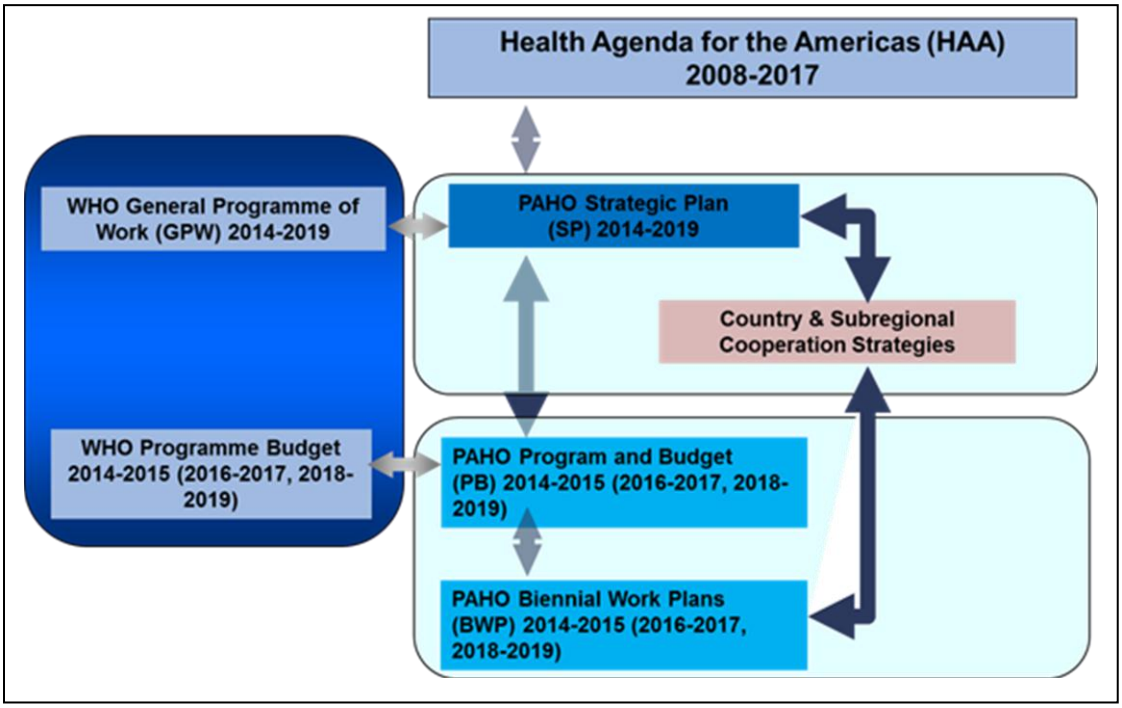
3. The SP 2014-2019 will enable PAHO to continue building on the public health gains achieved thus far in the Region of the Americas ("the Region"). It will also enable PAHO to guide interventions that address both new and existing challenges affecting the Region. The SP 2014-2019 will continue to build on PAHO's rich experiences as well as on lessons learned during previous planning periods. The plan will support the continuing effort to increase the accountability, transparency, and effectiveness of PAHO's work, in line with its Results-based Management (RBM) framework and the new PAHO Budget Policy.

4. The SP 2014-2019 represents an important milestone in enhancing the alignment and synchronization with WHO planning, programming, and budgeting processes, given that—for the very first time—WHO's GPW is being developed prior to PAHO's Strategic Plan. The Plan also benefitted from input provided by the Mid-term Evaluation of the Health Agenda for the Americas that was conducted in 2012. Furthermore, the SP 2014-2019 is shaped by the vision of the new PASB Director, "Championing Health in the Americas: Sustainable Development and Equity"; the push toward achieving the

Millennium Development Goals (MDGs); and health in the post-2015 development agenda. Other key inputs include a review of regional public health strategies and plans of action. The Plan will also contribute to strengthening the United Nations development system in line with the Quadrennial Comprehensive Policy Review.

5. Figure 1 shows the key elements of PAHO planning frameworks and their alignment with the Health Agenda for the Americas 2008-2017 as well as with WHO's planning frameworks. The SP 2014-2019 will be implemented over the course of three consecutive programs and budgets (2014-2015, 2016-2017, and 2018-2019). Increased alignment and harmonization between the Strategic Plan and the CCSs is an important aspect of the formulation and implementation of the Plan. The Biennial Work Plans (BWPs) are operational plans developed by PASB entities to implement the Program and Budget, and by extension the PAHO Strategic Plan.

Figure 1. PAHO and WHO Planning Frameworks

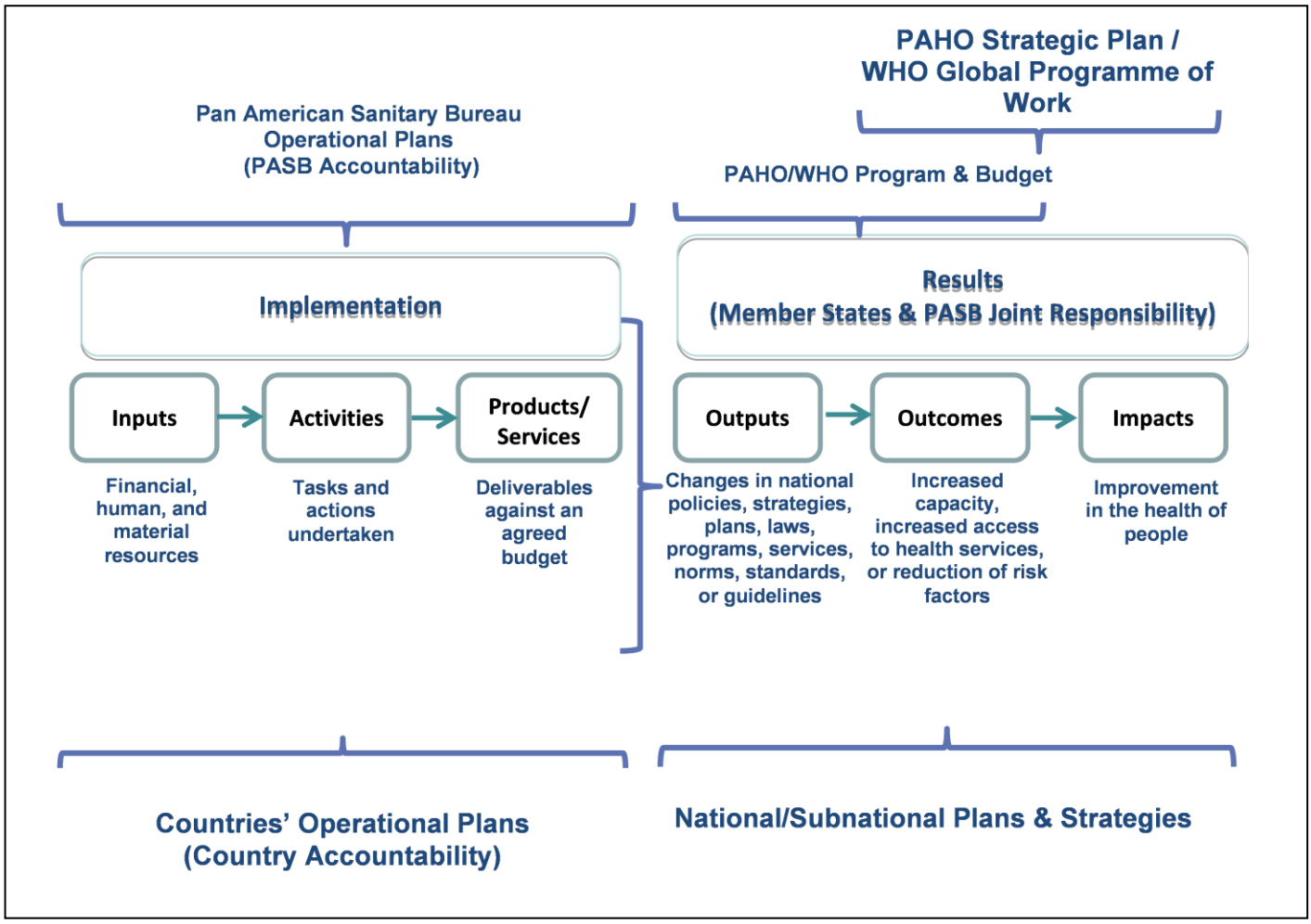


6. **Results chain:** The SP 2014-2019 adapts the WHO results chain, clearly identifying the relationship between levels of planning instruments as well as the accountability and respective responsibilities of the PAHO Member States and the PASB. Considering that the Plan is a joint commitment of PAHO Member States and the PASB, the anticipated results are derived from the implementation of individual countries' plans or strategies (at national or subnational level), the PASB operational plans, and the

collective efforts of the Organization, as shown in Figure 2. Section VIII includes the details on monitoring, reporting, accountability, and transparency for the Plan.

7. The Strategic Plan and the Program and Budget together cover the complete chain of results. The Strategic Plan will contain impact and outcome results with their respective indicators, while the PB outlines the outputs that Member States and the PASB agree jointly to achieve in a particular biennium, as well as the biennial outcome indicator targets.

Figure 2. PAHO/WHO Results Chain



8. **Impacts** are sustainable changes in the health of the population to which PAHO Member States, the PASB, and other partners contribute. Such changes will be assessed through impact indicators that reflect a reduction in morbidity or mortality or improvements in well-being of the population (i.e., increases in people's healthy life

expectancy). Consequently, implementing the PAHO Strategic Plan will also contribute to both regional and global health and development.

9. **Outcomes** are the collective or individual changes in the factors that affect the health of populations, to which the work of the Member States and the PASB will contribute. These include, but are not limited to, increased capacity, increased service coverage or access to services, and/or reduction of health-related risks. Member States are responsible for achieving outcomes, in collaboration with the PASB and other PAHO partners. The outcomes contribute to the Plan's impact goals. Progress made toward achieving outcomes will be assessed with corresponding indicators that measure changes at national or regional level.

10. **Outputs** are changes in national systems, services, and tools derived from the collaboration between the PASB and PAHO Member States, for which they are jointly responsible. These outputs include, but are not limited to, changes in national policies, strategies, plans, laws, programs, services, norms, standards, and/or guidelines. The outputs will be defined in the respective PB and will be assessed with a defined set of output indicators that will measure the PASB's ability to influence such changes.

11. It is noted that for Category 6 (Corporate Services/Enabling Functions), the outputs and outcomes will reflect institutional changes that support the efficient and effective delivery of technical cooperation by the Organization in the other five programmatic categories.

12. The PASB **operational plans** include the following components:

(a) Products and services: deliverables against an agreed budget for which the PASB is directly accountable during the biennium. Products and services are tangible and observable.

(b) Activities: actions that turn inputs into products or services.

(c) Inputs: resources (human, financial, material and other) that the PASB will allocate to activities and that produce products or services.

13. The operational planning components are necessary in order to achieve the outputs and contribute to the outcomes and impacts. The PASB operational planning components are not included in the Organization's PB; they are included in the operational plans of the different PASB entities (offices, departments, or units). Member States participate directly in the PASB operational planning process through the PAHO/WHO Representative Offices.

14. **Risks and assumptions:** The full results chain is predicated upon a number of risks and assumptions. They include the premise that resources and country collaboration

are in place to ensure that interventions contribute to and achieve the outputs and outcomes as outlined in the Plan. This will contribute to the realization of the impact results and by extension the strategic vision of the Plan.

15. **Lessons learned:** The PAHO SP 2014-2019 builds on experiences and lessons learned from previous plans, programs, budgets, and other high-level planning instruments and processes, including those of the WHO. Particular emphasis has been placed on the lessons learned from the PAHO Strategic Plan 2008-2013, given that this was the first plan to have been implemented using the Results-based Management approach and the first to be aligned with WHO's planning and budgeting processes. The application of these lessons will be essential for the successful implementation of the Plan and for continuing improvement in the efficient and effective management of the Organization. Key lessons learned are outlined below, and Annex I includes additional details.

(a) Increased ownership and involvement of Member States in the development and implementation of the Plan, particularly in setting priorities and targets, is critical for successful implementation of the Plan.

(b) Implementation of all aspects of the RBM framework is necessary and should be accompanied by simplification of processes, improvements in the quality of indicators, delegation of authority, and mechanisms for accountability.

(c) Enhanced programmatic alignment with WHO will facilitate better program management, optimization of resources, and improve monitoring and reporting processes.

(d) Greater coherence is needed between the different planning frameworks and the Strategic Plan, including the CCSs, regional plans, and strategies.

(e) Allocation of resources should be improved, according to programmatic priorities and using objective prioritization criteria and methodology.

(f) A basic level of funding for country presence, as addressed in the new budget policy, should be ensured by the Organization in order to effectively deliver technical cooperation programs to Member States.

(g) National voluntary contributions should be included in the Program and Budget to provide a full appreciation of the contribution of the Member States to the work of the Organization.

(h) Efforts to increase efficiencies should be continued, including through cost containment measures, use of technology and innovation, and new modalities of technical cooperation.

IV. Taking Stock and Moving Forward

16. Over the past decade the Region of the Americas has made sustained progress in improving the health of its population, but it still faces important gaps and emerging issues that countries are attempting to solve both individually and collectively. This analysis highlights the leading health gains, gaps, and trends in the Region as the basis for defining the strategic agenda and corresponding interventions outlined in the SP 2014-2019. The analysis draws on recent information in Health in the Americas 2012, the Mid-term Evaluation of the Health Agenda for the Americas 2008-2017, a review of the Country Cooperation Strategies (CCS), and a review of reports on PAHO's strategies and plans of action, among other sources.

Political, Economic, Social, and Environmental Context

17. The Region continues to move toward greater **democracy**, with notable progress in a number of areas. Countries are undertaking reviews of their constitutional frameworks and initiating more transparent electoral and participatory processes. There is a gradual trend from electoral democracy toward participatory democracy, with growing decentralization, greater community empowerment, redistribution of power, and new concepts of citizenship.

18. Countries of the Region are becoming increasingly integrated into the global economy, a process that is considered to hold potential benefits for Latin America.

19. Countries of the Region are participating in various alliances, initiatives, and blocs based on geographic proximity and/or on shared commercial, cultural, or political interests. Countries are playing a more prominent role in global strategic blocs such as the Organisation for Economic Co-operation and Development (OECD), the Group of 20 (G20), the forum for Asia-Pacific Economic Cooperation (APEC), and the BRICS group (Brazil, Russia, India, China, and South Africa). Furthermore, new partnerships and forums have recently emerged within the Region, including the Bolivarian Alliance for the Peoples of Our America (known by its Spanish acronym, ALBA), the Union of South American Nations (UNASUR), and the Community of Latin American and Caribbean States, which coexist with older regional and subregional entities.

20. There is a shift in the operations of social networks in the Region, driven by the rapid expansion of Internet services, growing use of mobile communications, and increased access to online information and services. While these trends are providing new opportunities to communicate, learn, and exchange information, they are also influencing changes in culture, lifestyles, behavior, and consumption patterns with direct impact on people's health. The Region of the Americas accounts for over 13 percent of all social networking minutes globally; it is estimated that nearly 115 million people in Latin

America alone visit a social networking site each day, representing 96 percent of the entire online population in the Region. The Latin American social networking audience is nearly equal in its composition of males and females, but females account for a larger share of social networking time spent.

21. Social media are redefining the way we think about communication in the area of health and health risks. New and emerging methods of communication emphasize interactive platforms, two-way communication, and the sharing of content, news, and feedback.

22. Since the 1990s, Latin American and Caribbean countries have made structural changes that include adjustments to social security, trade, tax, and finance programs. In some cases these have included massive privatizations. These changes have not always been coupled with public investments in health, education, infrastructure, and environmental protection. This highlights the need for structural changes that increase support to and harmonization of these vital sectors. Although still controversial, evidence suggests that public investments in the health and human capital of poor people have contributed substantially to reducing poverty in many Latin American countries.

23. Although Latin American countries did not escape the effects of the global economic and financial recession, they have weathered the crisis more successfully than other regions of the world, showing faster signs of recovery. Between 2008 and 2010, most of the Region's countries implemented anti-cyclical economic policies to counteract and mitigate the cycle. Such measures protected, and in some cases even expanded, public social spending. Of particular note are conditional cash transfer programs, which by 2010 amounted to 3% of total gross domestic product (GDP) in Latin American countries.

24. Due to the unfavorable international context, economic growth in Latin America and the Caribbean slowed during 2012, although the positive trend continues. Regional GDP grew by an estimated 3.1% in 2012, about one percentage point lower than in the preceding year. The slowdown affected most of the South American countries, whose GDP growth was estimated at 2.7% in 2012 (1.8 percentage points less than the 4.5% registered in 2011). By contrast, the countries of Central America registered a growth rate similar to the preceding year, while the Caribbean showed slightly higher growth. This lower performance of the largest economies in South America decisively influenced the regional trend. Despite the slowdown of GDP growth in the Region, most of the countries maintained a positive growth rate, which is mainly explained by the dynamics of domestic demand and, to some extent, by the relatively favorable performance of investments and exports in some countries.

25. Recent estimates show that GDP growth in four countries in the Region will exceed 5% in 2012: Panama (10.5%), Peru (6.2%), Chile (5.5%), and Venezuela (5.3%). Another group of countries, including Bolivia, Colombia, Costa Rica, Ecuador, and Nicaragua, are projected to grow between 4% and 5%. A third group is projected to grow between 1% and 4%: Argentina, Brazil, Canada, Cuba, Dominican Republic, El Salvador, Guatemala, Honduras, Mexico, United States of America, and Uruguay. The Caribbean countries are projected to grow 1.1%, after a weak performance in 2011. Paraguay is the only country where GDP is projected to fall, by 1.8%, in 2012.

Social Determinants of Health

26. Income, employment situation, education, and housing are among the most relevant social determinants of health, with influence on other intermediate and proximal determinants of health.

27. Human development indicators are improving in the Region. Between 2000 and 2012, the Human Development Index (HDI) value increased from 0.683 to 0.741 in Latin America, 0.632 to 0.687 in the Caribbean, and 0.906 to 0.935 in North America. Latin America has reached what the United Nations Development Programme (UNDP) considers to be a high level of human development (0.711). However, differences still exist between and within countries, as shown by the lower HDI figures for the Caribbean countries.

28. Despite these encouraging indicators, **poverty and inequities** continue to be challenges for the Region. Some recent evidence qualifies Latin America and the Caribbean (LAC) as the most inequitable region in the world, with 29% of the population below the poverty line and the poorest 40% of the population receiving less than 15% of total income. On the other hand, evidence points toward an overall reduction in income inequality. During the first decade of this century, income inequality declined in most Latin American countries, with significant declines registered in Argentina, Bolivia, Brazil, Chile, Dominican Republic, Ecuador, El Salvador, Mexico, Panama, Paraguay, Peru, and Venezuela. However, there were increases in income inequality in Guatemala, Honduras, Nicaragua, and Uruguay. Despite the level of macroeconomic stabilization, there is an ongoing debate on the need to intensify reforms in certain critical areas—fiscal, labor, judicial, and social protection, among others.

29. The increase in **employment** income and the effect of redistributive income policies implemented through programs that provide more progressive and sustained conditional cash transfers to the most vulnerable groups have had a positive impact on poverty and inequality levels in the Region.

30. In terms of employment, the main labor market indicators in LAC continued to improve during 2012, despite the economic slowdown associated with the international situation, especially in the developed countries. The urban unemployment rate (6.5% of the economically active population) continued to decline until the third quarter of 2012, when it was less than four-tenths of one percent compared to the same period in 2011.

31. By the end of 2012, the regional urban unemployment rate was estimated at 6.4%, 0.3% below registered unemployment in 2011. Over this time period, urban unemployment decreased by 400,000 people.

32. The overall unemployment rate decreased for women and men in most countries of LAC in 2012. However, gender gaps persist in employment, as unemployment among women continues to be 1.4 times the male unemployment rate. By the third quarter of 2012, the regional unemployment rate was 7.7% for women and 5.6% for men. A decline was also observed in the unemployment rate for young people, which moved from 15.2% to 14.3%. Despite this progress, there are still concerns about the exclusion of young people from the labor market, as youth unemployment is triple that of the adult population.

33. Payroll employment continued to grow more vigorously than self-employment in some of the countries, which is an indication of labor market modernization and the growth of the formal sector in these countries. Payroll employment grew in Brazil (2.3%), Chile (4.0%), Colombia (4.4%), Panama (5.5%), and Venezuela (3%). By contrast, payroll employment in Argentina experienced a decline (-2.2%). Self-employment grew in Ecuador and Mexico in line with the increase in overall employment rate (3.3% and 4.0%, respectively). With the persistence of informal employment, consideration has to be given to the quality of employment and to conditions at the work site.

34. **Education** and health are cornerstones of development. Clearly, there is a synergistic relationship between the two. A boost in educational levels is associated with improvements in population health and increases in productivity, social mobility, poverty reduction, and citizenship building. In LAC, significant advances have been made toward achieving universal primary education. In 1990, access to primary education was available to 88% of all boys and girls, and by 2010 such coverage reached 95%, with some countries having up to 99%. The school lag—measured by the number of girls and boys who drop out of primary school or do not finish their last year in the period assigned—is very important for the health sector. Adolescent pregnancy is most concentrated among girls who have dropped out of school, and, subsequently, where the highest child mortality and morbidity rates are seen.

35. Educational capital is passed from one family generation to the next. For example, children whose parents did not complete their basic education are less likely to complete secondary education. Around half of LAC's population has completed secondary school. However, in six countries this number does not exceed 38%. Various studies hold that finishing secondary education constitutes the bare minimum of schooling that a person needs to improve his or her living conditions.

36. **Gender equity and ethnic equity** are increasingly a part of the political agendas of many of the Region's countries, as more and more women assume leadership positions. Although the number of women who hold such positions is still insufficient, women's participation and representation in LAC's political and electoral life hovered at around 20% in 2010. In 2011, five of the Region's countries were governed by women. There also has been greater empowerment and recognition of the rights and contributions of women and of indigenous and Afro-descendant populations, as well as groups of diverse sexual orientation, including lesbians, gays, and transgender persons.

37. In LAC, women account for the majority of caregivers (90%) to the elderly. Women shoulder a physical and economic burden that is not remunerated or acknowledged. Available evidence indicates that with the aging of the population, the epidemic increase in chronic diseases and disability, and the limited institutional response, women's unremunerated workload in providing care for the elderly will continue to rise.

38. Poverty reduction programs have promoted women's greater control over their resources, including access to health care and education. In the Region of the Americas, women as a group have surpassed men in terms of schooling. However, these gains are not fully reflected in economic well-being, especially in terms of wages, where women continue to lag behind men.

39. Some 1,100 indigenous groups live in the Region. Indigenous groups represent 10% of the total population in LAC, 4% in Canada, and 1.6% in the United States. Regardless of their country of residence, indigenous and other ethnic groups, along with Afro-descendants, suffer varying degrees of social exclusion and vulnerability. According to the World Bank, some of these populations receive only 46% to 60% of what nonindigenous populations earn. Given the current levels of poverty and social exclusion among discriminated ethnic groups, it can be expected that negative impacts on health will persist across generations.

Demographic Trends

40. Between 2005 and 2012, the Region's **total population** rose from 886 million inhabitants to 954 million. However, a relative deceleration in demographic expansion is

underway. From 1.3% in 1995-2000, average annual population growth at the regional level dropped to 1% in 2005-2012.

41. Between 2005 and 2012, the Region's **total mortality** rate declined, from 6.9 to 5.9 per 1,000 population. The total fertility rate for the same period dropped from 2.3 to 2.1 children per woman. Demographic changes show different evolutionary gradients from country to country. For example, while Cuba reports a rate of 1.5 children per woman (considerably lower than the population replacement level), Guatemala and Bolivia show rates of 4.0 and 3.3, respectively. Between 2005 and 2012, life expectancy in the Americas for both sexes is estimated to have risen from 72.2 to 76.4 years—a four-year increase in one decade—with an additional increase of 6.5 years projected for 2050. However, differences among countries persist.

42. In 2012, greater than 100 million **people over 60 years of age** lived in the Region. By 2020 this figure is expected to double, and more than half of these people will live in Latin America and the Caribbean. A total of 69% of all those born in North America and 50% of those born in LAC will live beyond age 80. Total dependency ratios are increasing. In 2010, the estimated total dependency ratio in LAC was 53.3, while in North America it was 49.0. By 2050, these figures are expected to rise to 57.0 and 67.1, respectively. In 2010, the highest proportion of dependency in the Region occurred among lower-income populations—which, in a pessimistic scenario, could help perpetuate the cycle of poverty.

43. Latin American countries without exception have an advantageous demographic situation for economic development, the so-called **"demographic bonus."** The first phase of this process is characterized by a ratio of more than two dependents per three economically active persons. In the second phase, regarded as the most favorable, the dependency ratio reaches a low level of fewer than two dependents per three active persons and remains steady. In the third phase the ratio is still favorable, with fewer than two dependents per three active persons, but it is changing because of the increasing number of old people. Overall, Latin America is in the second phase of the demographic bonus. This phase started by the beginning of the 21st century and is expected to last until the end of the 2011-2020 decade, when the third phase is expected to start and extend to the early 2040s. Eight countries are in the first phase of the demographic bonus: Bolivia, Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, and Paraguay. Another eight are in the second phase: Argentina, Colombia, Costa Rica, Ecuador, Mexico, Panama, Peru, and Venezuela. Just three are in the third phase: Brazil, Cuba, and Chile.

Environment and Health

44. Population growth, the demographic bonus, and aging are demographic trends that, in tandem with urbanization, have a direct influence on the environment and its

sustainability. Almost 80 percent of the LAC population lives in **urban areas**, but there are considerable variations within the Region, across subregions and countries. Countries and territories with highly urbanized populations (over 77%) include Anguilla, Argentina, Bermuda, Brazil, Canada, Cayman Islands, Chile, Guadeloupe, Mexico, Peru, Puerto Rico, United States, Uruguay, US Virgin Islands, and Venezuela. Those with low urbanization (below 50%) include Antigua and Barbuda, Aruba, Barbados, British Virgin Islands, Grenada, Guatemala, Guyana, Montserrat, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago.

45. Although the Region of the Americas has already reached the Millennium Development Goal (MDG) for access to improved **drinking water** sources and **basic sanitation** and is on track to reach the sanitation target for 2015, marked inequalities also persist between and within countries. As of 2010, 36 million people in the Region did not have access to drinking water fit for human consumption, and approximately 120 million lacked improved wastewater and sewage disposal services; nearly 25 million people in Latin America and the Caribbean defecate outdoors. Low safe water and sanitation coverage tends to be observed among people in lower income quintiles. Water, sanitation, and hygiene, particularly for the most vulnerable population needs ongoing support.

46. Latin America produces approximately 436,000 daily tons of urban **solid waste** and more than 600 daily tons of hazardous waste generated by health facilities. More than half of the urban population in Latin America is served by adequate sanitary landfills. However, despite current environmental legislation that prohibits disposal of special and hazardous waste without prior treatment, it is frequently disposed of alongside common waste in many LAC countries.

47. Approximately, a quarter of a million premature deaths per year in the Region are attributed to **ambient air pollution**; 110,000 of these deaths occur in Canada and the United States, and 140,000 in LAC. The average disease burden attributable to air pollution ranges from 0.8% of healthy life years lost in the Southern Cone countries (Argentina, Chile, and Uruguay) to 3% of healthy life years lost in the Andean countries (Bolivia, Ecuador, and Peru). Respiratory diseases, which are one of the most documented effects of air pollution, are the leading cause of death among children under 5 in Central America and are among the three leading causes of death in all countries except the United States and Canada. This situation has not changed significantly between 1990 and 2010. It is estimated that more than 100 million people in the Region are exposed to concentrations of environmental contaminants exceeding the recommended limits in WHO air quality guidelines. **Indoor air pollution** from the burning of solid fuels is the environmental risk with the greatest disease burden in LAC.

48. **Pesticide contamination** is a prevalent problem in the Region. It has been most extensively documented in Central America, where 33 million kilos of active ingredient were imported each year between 1977 and 2006. Seventy-seven percent of these are persistent organic pollutants that should be eliminated, according to the Stockholm Convention.

49. Issues regarding the control and management of **chemical risks** have acquired particular relevance considering the growth of mining activity. In Latin America, mining increased from 4.3% of regional GDP in 2001 to 6.1% in 2011. Mining activity doubled and tripled in various countries during that period, contributing as much as 11% to 27% of national GDP. Although the expansion of mining is positive from an economic point of view, it has direct and indirect impacts on health and the environment that can result in higher costs to public health. This means that impact assessments are essential.

50. Vulnerability to **natural disasters** is a global problem. Of the 63 LAC cities with one million or more inhabitants, 38 are in areas at greatest risk for at least one type of natural disaster, six are in areas at greatest risk for two types, and two are in areas at greatest risk for three or more types. Many populations in situations of socioeconomic vulnerability are settled on lands that are potentially affected by climate change, but they have less capacity to deal with environmental risks. Higher rainfall caused by extreme weather phenomena connected to climate change leads to increased deposits of chemical contaminants such as nutrients and fertilizers in coastal zones, supporting the proliferation of toxic algal blooms that cause food poisoning. This phenomenon has increased along all coastlines, especially in the Caribbean. These changes have implications for food and nutrition security and safety and for safe drinking water, as well as for the prevalence of vector-borne diseases.

Regional Health

51. Given the 2015 target date for the **MDGs**, 84% of the time for achieving these goals has already passed. The Region has made progress but challenges remain, as outlined below.

52. **Infant mortality** continues to decline in the Region. In Latin America and the Caribbean, the infant mortality rate (IMR) was 42 per 1,000 live births (lb) in 1990 and 16 per 1,000 in 2011, a decrease of 62%. In 2011 there were approximately 170,000 child deaths in the Americas. Nine of 34 countries from LAC with available information reached the Millennium Development Goal in 2000, 17 may be on track to reach it by 2015, and eight will not reach the goal. Lower infant mortality rates are observed in Barbados, Canada, Chile, Costa Rica, Cuba, the United States, and Uruguay (5 to 12 per 1,000 live births), while the highest rates are in Bolivia and Haiti (40 to 45 per 1,000 live births). In the Caribbean countries, infant mortality rates are more unstable because they

are small populations; the situation is more homogeneous than in Latin American countries. The French overseas departments (French Guiana, Guadeloupe, and Martinique) and Anguilla have the lowest IMR in the Caribbean, less than 12 per 1,000 live births, while Guyana and Suriname have the highest, 39 and 26 per 1,000 respectively. Public health actions that have contributed to the overall decline include the advancement of primary health care, expanded vaccination programs, oral rehydration therapy, improved maternal and child health services, family planning, and increased coverage of basic services (mainly water and sanitation). Increased educational levels of the population and poverty reduction also contributed to the decline in IMR.

53. **Maternal mortality** remains an unresolved challenge. Many countries in the Region will fail to meet the MDG target by 2015. While there is an overall decline in the maternal mortality ratio (MMR) in the Region, the trends differ between countries. Based on estimates from the UN Maternal Mortality Estimation Inter-Agency Group, the MMR in 1990 was 140 per 100,000 live births in Latin America and the Caribbean and 80 in 2010, a reduction of 41%, with an average annual decline of 2.6%. In Latin America the ratio fell from 130 to 72 in 2010, a 43% reduction, with an annual average decline of 2.8%. In the Caribbean the ratio fell from 280 to 190, a 30% reduction, with an annual average decline of 1.8%. In 2010, there were an estimated 9,726 maternal deaths in the Americas.

54. An analysis of data for 1990-2011 from 33 countries and territories in the Region shows reductions of the MMR in 25 countries. Among the subregions, North America has the lowest ratios. The Central American countries saw reductions of the MMR between 8.0% and 54.5%. In some Latin Caribbean countries there were decreases varying between 9.6% and 57.5%, and further increases from 15.9% to 86.4%. Almost all of the Andean and Southern Cone countries show declines between 2.1% and 66.5%. It is important to note that in several countries the expansion of antenatal care coverage, delivery care by trained staff, and access to and use of contraceptives are contributing to declines in the MMR. The MMR increases seen in some contexts may be due to improved surveillance and reporting of events and not necessarily to a real increase in mortality.

55. Over the period 2009-2011, there was a reduction in new **HIV** (human immunodeficiency virus) infections estimated for the countries of the Region, as well as a decrease in HIV-related morbidity and mortality. In 2011, about 6% of all new HIV infections worldwide were in the Region of the Americas (147,000 cases). Of these, 83,000 are in Latin America, 51,000 in North America, and 13,000 in the Caribbean. The Caribbean has been one of the subregions with the largest decrease in the number of new infections (42% fewer new infections). Also, the number of children who contracted HIV fell by 24% in Latin America and 32% in the Caribbean in two years (2009-2011). If these trends continue, most countries will reach the MDG target of halting and beginning

to reverse the spread of HIV and AIDS (acquired immunodeficiency syndrome). However, certain populations are facing higher deleterious impact, but there is limited evidence of reversal (e.g., men who have sex with men, sex workers, and mobile populations). By the end of 2011, the percentage of people in LAC with HIV who need treatment and receive it was 68%, higher than the world average of 54%. Among HIV-positive pregnant women, the percentage who received antiretroviral drugs in LAC increased from 36% in 2005 to 70% in 2011.

56. For the period 2000-2011, the number of microscopically confirmed cases of **malaria** in the Region decreased from 1.18 million to 490,000, a 58% reduction in morbidity. Over the same period, mortality declined by 70%. Of the 21 malaria-endemic countries in the Region of the Americas, 13 achieved a reduction in malaria incidence rates of ≥75% between 2000 and 2011 (Argentina, Belize, Bolivia, Costa Rica, Ecuador, El Salvador, French Guiana, Guatemala, Honduras, Mexico, Nicaragua, Paraguay, and Suriname). Three countries are on track to achieve a reduction of 75% by 2015 (Colombia, Panama, and Peru), and Brazil is projected to reduce incidence rates by 50%-75%.

57. Approximately 30% of the population of the 21 malaria-endemic countries is at some degree of risk for malaria infection, and about 8% is at high risk. Argentina, Costa Rica, Ecuador, El Salvador, Mexico, and Paraguay are in the pre-elimination phase. The 15 other endemic countries are all in the control phase. The link between decreases in malaria cases and implementation of vector control is not always clear-cut. In five countries (Costa Rica, Dominican Republic, Ecuador, Nicaragua, and Venezuela), coverage of high-risk populations with either insecticide-treated mosquito nets or indoor residual spraying exceeded 50%, and only in three of these countries (Costa Rica, Ecuador, and Nicaragua) have malaria cases decreased by more than 50%. Reports on the availability of artemisinin-based combination therapies (ACTs) were complete for only three of the eight countries that have resistance to chloroquine and that therefore use ACTs. Based on the available information, therefore, the association between prevention or treatment (with anti-malarial drugs) and malaria trends across the endemic countries in the Region of the Americas is inconsistent and requires further in-depth evaluation.

58. The 35 Member States have advanced on tuberculosis control, with an estimated 84% case detection rate for the Region in 2011. However, multidrug-resistant tuberculosis (MDR-TB) and TB/HIV co-infection remain significant challenges, despite advances in their control, as noted in the 2012 Mid-term Evaluation of the Health Agenda for the Americas. The WHO report of 2012 on tuberculosis control indicates a 4% annual decline in the incidence of TB in the Americas, the greatest regional decline recorded globally. The Region of the Americas has reached and surpassed the targets set for 2015 of 50% reduction in the prevalence and mortality from TB.

59. Some 250 million people in the Region suffer from one or more **noncommunicable diseases** (NCDs). In 2007, 3.9 million people in the Americas died from NCDs, 37% of whom were under age 70. Shared risk factors for NCDs are tobacco consumption, harmful use of alcohol, unhealthy diet, and physical inactivity. **Cardiovascular diseases** (CVDs) are the leading cause of death from NCDs. **Hypertension** shares risk factors for other chronic diseases. Of premature deaths from CVDs, 30% occur in the poorest quintile of the population, with only 13% corresponding to the richest quintile. Premature deaths from CVDs are more frequent among men than women and occur at the age of greatest productivity, causing the severe economic and social damage. The recent Mid-term Evaluation of the Health Agenda highlights rising **obesity** in the adult population, especially among women, as a major risk factor for NCDs.

60. Between 2000 and 2007, mortality from CVDs in the Region dropped by 19%, from 207.8 deaths per 100,000 population to 167.9. During the same period, while North America experienced a 25% decline, from 192.3 deaths per 100,000 population to 144.2, the non-Latin Caribbean experienced a 14% drop, from 296.4 deaths per 100,000 population to 254.9. Latin America also experienced a 14% drop between 2000 and 2009, from 229.9 deaths per 100,000 population to 191.4. Although the reductions observed in North America and Latin America were linear and statistically significant, the decline in the non-Latin Caribbean was statistically significant but nonlinear.

61. **Malignant neoplasms** are the second leading cause of death in the countries of the Americas, with the most common cancers being those of the lung, stomach, colon, and breast. Cancer incidence, including incidence of cervical cancer among women and prostate cancer among men, is highest in low- and middle-income countries. The incidence of malignant neoplasms depends on complex interrelationships among biological, genetic, and lifestyle factors; it also encompasses social determinants such as poverty, education, employment, housing, transportation, pollution, and nutrition. Key to cancer prevention are actions geared to the identification of population exposure and to protection against known and suspected human carcinogens, of which there are at least 245. An important factor to consider is whether exposure to risk factors is voluntary (for example, tobacco smoking) or involuntary. The weight of each of these factors varies by degree and intensity of exposure and by social gradient, generating an unequal burden of disease. These factors are not always sufficiently characterized, nor are the interconnections among them sufficiently well established. In the Americas, cancer deaths are on the decline. From 2000 to 2007, the age-adjusted mortality from malignant neoplasms fell by 8%, from 131.3 deaths per 100,000 population to 121.3. Estimates indicate that between 50% and 60% of all cancer deaths can be prevented, but achieving this will require implementing many regulatory measures as well as encouraging lifestyle changes. Early detection and effective treatment also are critical for improving cancer patients' quality of life.

62. **Diabetes mellitus** causes around 242,000 deaths annually in the Region; estimates show that 22,000 (8%) are avoidable, considering that they occur among people younger than 50 years of age. The pattern of mortality from this disease varies among countries. While the rate of diabetes incidence is declining in some countries (e.g., Argentina, Canada, and the United States), it is rising in others (e.g., Cuba, Ecuador, El Salvador, and Mexico). It is important to keep in mind that in many deaths of people with diabetes, the disease is not recorded as the underlying cause of death; rather, these deaths are attributed to other diseases or to associated chronic complications such as cardiovascular or renal disease. Forecasts indicate that the number of people with diabetes in the Americas will increase from 62.8 million in 2011 to over 91 million in 2030. The rate of increase could be lowered if prevention measures were strengthened, the obesity epidemic curbed, and better results obtained in health care for those who are already suffering from the disease.

63. **Chronic kidney disease** (CKD), caused mainly by complications from diabetes and hypertension, is another condition that has increased in the Region. From 1990 to 2010, disability-adjusted life years (DALYs) due to CKD increased 20% in the United States and 58% in LAC. Many Central American countries have recognized the need to better understand the magnitude and causes of a severe type of CKD, unrelated to diabetes and hypertension, and to develop strategies to control it. This severe disease primarily affects young men working in the agricultural sector, a situation that is having a dramatic social and economic impact on families, communities, and health services. Recently, the WHO Global Burden of Disease project estimated an increase of 99% and 127% from 1990 to 2010 in DALYs and years of life lost, respectively, in Central America due to CKD.

64. Reports indicate that in the Region of the Americas, reducing **tobacco** consumption by 20% and **salt intake** by 15%, while treating patients at high risk of CVDs with a combination of appropriate drugs, could prevent up to 3.4 million deaths at reasonable cost in 10 years. Such evidence strengthens the argument that countries, guided by well-informed leadership within the ministries of health, can continue to advocate for multisectoral policies that promote responsible, prevention-based individual self-care and improve the availability of essential medicines.

65. At the regional level, rapid and deleterious changes are taking place in **food consumption** and eating habits. These shifts affect broad sectors of the population, especially low-income and less-educated segments. An alarming epidemic of **overweight and obesity** has been caused by the consumption of high-calorie processed foods rich in fats and sugars, in addition to a significant decrease in fruit and vegetable consumption, and a reduction in physical activity. Regionwide estimates indicate that between 50% and 60% of all adults, over one-third of all adolescents, and between 7% and 12% of all children under 5 are either overweight or obese. Even worse, forecasts indicate that this

figure will rapidly rise, reaching 289 million people (39% of the total population) by 2015. In almost all countries, the problem is greater among women. An analysis of 57 prospective studies points out that every excess 5 kg/m2 on the body mass index (BMI) is associated with an increase in mortality of nearly 30% (40% from CVDs, 60%-120% from diabetes-related complications, 10% from cancer, and 20% from chronic respiratory illnesses).

66. **Mental disorders** in LAC, despite low mortality rates, are responsible for nearly 22% of the total burden of disease as expressed in DALYs. Depression and alcohol-related disorders rank first and second, respectively, in terms of disease burden. While most countries have made great progress in reforming services and protecting the human rights of people with mental disorders, challenges persist, particularly the underreporting of cases and the gap in access to, and quality of, treatment. Countries allocate less than 2% of their health budgets to mental health, and 67% of that percentage is earmarked for psychiatric hospitals.

67. Mortality due to **external causes** (those different from natural causes and recognized as avoidable, such as homicides, accidents, and suicides) remain an important public health problem in the Region. It is estimated that over 5.5 million people died from these causes between 1999 and 2009. Three and a half million deaths (64%) occurred in this period among the youth and adult population (10-49 years old), with an average of 319,000 deaths per year. Of total deaths from external causes, 84% happened among males, five times more than among women. The most frequent external causes were homicides (33%) and land transport accidents (26%). Gender-based violence, including sexual violence, continues to be a growing problem and a major public health challenge.

The Health System Response

68. The Region’s health systems are characterized by their segmentation, manifested by a variety of financing and affiliation mechanisms. The supply of health services also is fragmented, with many different institutions, facilities, or units that are not integrated into the health care network. Both of these characteristics increase the inequity in access and reduce efficiency in terms of health care delivery and service management.

69. The underlying reasons for this segmentation and fragmentation are complex. They frequently reflect systemic factors of a social, political, and economic nature that have been accumulating over time and have passed down from one generation to the next. In this context, the health services themselves become an important health determinant. Health Services have the potential to help improve equity insofar as they advance universal coverage financed through progressive public resources that reduce

out-of-pocket expenditures to a minimum and eliminate discriminatory practices and differential quality of care.

70. In recent years, the Region's countries have progressed toward the universalization of health systems through policy reforms and changes that emphasize the right to health. Nonetheless, several challenges persist, particularly with respect to how to advance toward comprehensive service coverage, reduce copayments and other out-of-pocket expenses, and guarantee similar benefits to all. Other important challenges include improvements to the quality of care and tailoring the response capacity of the services to health care demand. Stronger efforts are needed to address these unresolved issues.

71. The Region recently celebrated the 30th anniversary of its launch of the primary health care (PHC) strategy and the goal of Health for All. On this occasion the Region reaffirmed the importance of effectively implementing the values and principles of the PHC strategy, including its comprehensive and multisectoral approach. In some countries of the Region, PHC practice has been limited to offering first-level care, frequently to low-income groups, with only a few health promotion and preventive activities. Such an approach compromises the response capacity during health crises.

72. It is encouraging to see, however, that several countries of the Region are making substantive efforts to incorporate PHC into their renewed health care models. Countries are trying to make PHC a component of a strengthened service network that is better equipped to respond to new demands generated by demographic, epidemiological, social, technological, and cultural changes, among others.

73. The most recent period has been characterized by a sustained dynamism in developing human resource policies, strategies, and plans in tune with global, regional, and national policies. There is now broad consensus in the Region on the steering role of the health authority for strengthening human resources. This implies seeking strategic coherence in the organization of health systems and services, while building a close relationship with training institutions. This approach has brought about an effective expansion of coverage through multidisciplinary family and community health teams, which are responsible for a given population and territory in rural, urban, outlying, and remote areas.

74. Although the countries of the Region have made progress in the area of human resources for health, they have not yet achieved a satisfactory composition or distribution of their health workforce. Improving governance and competencies of health workers, in collaboration with the education sector, to reduce some of the prevailing incoherencies and imbalances remains a critical challenge. The rigid hierarchy that prevails among the different professional categories, making collaborative practices difficult or impossible, is an additional issue to be addressed. In some countries, reforms and programs face

structural problems that are difficult to resolve. This is reflected in the massive emigration of health workers from the countries of the Caribbean.

75. In the United States of America, more than 15 million people were working in the health sector in 2009, representing 11% of the country's total workforce. This included 784,000 doctors, of whom 305,000 were devoted to providing first-level care. However, compliance with the Affordable Care Act, by widening access to health care, could result in a shortage of providers. One study projects a shortage of some 63,000 physicians by 2015, with shortages steadily increasing until 2025.

76. Throughout the history of LAC, expanding health service coverage has been the main objective for several countries. Evidence indicates, however, that quality of care is also pivotal for maintaining and improving individual and population health.

77. From 2005 to 2010, total health expenditure in LAC as a percentage of the GDP rose from 6.8% to 7.3%. During the same period, average public health expenditure in LAC increased from 3.3% to 4.1% of GDP, while in Canada it rose from 7.1% to 8.4% and in the United States, from 6.4% to 8.0%. Also during that period, out-of-pocket health expenditures in LAC dropped from 3.5% to 3.2% of GDP. In 2010, total per capita health expenditure ranged from US$ 90 in Bolivia to US$ 2,711 in the Bahamas, US$ 5,499 in Canada, and US$ 8,463 in the United States. Health expenditures related to purchasing goods and services was more than eight times higher in the United States than in LAC.

78. Although per capita expenditure is relevant, no linear relationship exists between the amount spent and health outcomes. Other variables also carry great weight, among them social protection policies (or lack thereof), health system management and organization, the scope of public health programs and health promotion activities, and regulation of the health market.

79. Direct out-of-pocket expenditures have an impoverishing effect on families. Experience indicates that providing universal coverage and pooling funds constitute the best options for protecting families' finances when they face catastrophic medical expenses. In the United States of America, the cost of health insurance policies rose by 72% between 2000 and 2008, financially affecting employers and employees; out-of-pocket expenditures increased by 44%. In 2010, health expenses incurred by people with NCDs represented 75% of all health expenditures. Hospitals that made up 1% of all health facilities spent 35% of the entire budget. Furthermore, as a result of the economic crisis, the population without health insurance in the United States America rose from 15.4% in 2008 to 16.7% in 2009 (46.3 and 50.7 million people, respectively).

80. Although in the past five years LAC countries have moved forward in formulating and implementing pharmaceutical policies, only a few have updated them. Including drugs as part of health guarantees is critical to ensuring real universal access to health services. In 2008, estimates show that in LAC, average annual per capita out-of-pocket expenditures for medicines amounted to US$ 97, ranging from US$ 7.50 in Bolivia to over US$ 160 in Argentina and Brazil. The use of generic drugs in the Region has not advanced as much as desirable, partly due to limited incentives and adequate regulatory frameworks.

81. The countries of the Americas differ widely in terms of the **coverage and quality** of their health information systems. A 2008 study revealed that 7 of 26 countries have improved the **coverage** of their vital statistics registries, exceeding 85% coverage at the national level. Seven other countries only record up to 50% of these events, or one of every two births or deaths. The low number of births in health facilities in some countries and the limitations of statistical offices are challenges that make it difficult for countries to improve the recording of vital statistics. In terms of **data quality**, a recent regional assessment showed that only 19 countries studied provided good data. Regarding **vital statistics**, a recent analysis in the Region shows that there is a growing awareness of the importance of registering all vital events and that coverage of births tends to rise when *(a)* the country accepts the right to identity as a human right, and *(b)* other sectors of society such as education and health require registration of these vital events. Regarding death registry, the monitoring of the commitments made by the countries to achieve the MDGs, especially in relation to infant and maternal mortality, has served as an important stimulus for countries to increase coverage.

V. Strategic Agenda

Strategic Overview

82. This section constitutes the core of the Strategic Plan. It sets out the Plan's strategic direction for the Organization over the next six years. The Plan is guided by PAHO's vision, mission and values.

PAHO's Vision, Mission, and Values

Vision
The Pan American Sanitary Bureau will be the major catalyst for ensuring that all the peoples of the Americas enjoy optimal health and contribute to the well-being of their families and communities.

Mission
To lead strategic collaborative efforts among Member States and other partners to promote equity in health, to combat disease, and to improve the quality of, and lengthen, the lives of the peoples of the Americas.

Values
Equity - Striving for fairness and justice by eliminating differences that are unnecessary and avoidable.
Excellence - Achieving the highest quality in what we do.
Solidarity - Promoting shared interests and responsibilities and enabling collective efforts to achieve common goals.
Respect - Embracing the dignity and diversity of individuals, groups, and countries.
Integrity - Assuring transparent, ethical, and accountable performance.

PAHO's Core Functions

1. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
2. Shaping the research agenda and stimulating the generation, dissemination, and application of valuable knowledge;
3. Setting norms and standards, and promoting and monitoring their implementation;
4. Articulating ethical and evidence-based policy options;
5. Establishing technical cooperation, catalyzing change, and building sustainable institutional capacity;
6. Monitoring the health situation and assessing health trends.

83. The Plan responds to the priorities set out in the Health Agenda for the Americas 2008-2017 and is also aligned with WHO's 12th GPW 2014-2019. The Plan responds to key regional mandates and countries' collective priorities as identified in the Country Cooperation Strategies and other national strategic documents.

84. Under the theme "Championing Health: Sustainable Development and Equity," the Plan will focus on reducing inequities in health in the Region within and among countries and territories in order to improve health outcomes. In line with this, the Plan's main strategies will: *(a)* promote health and well-being; *(b)* advocate for a multisectoral approach aimed at addressing the social determinants of health; and *(c)* foster collaboration with all the countries and territories toward the progressive realization of universal health coverage. Specific strategies are outlined under each category according to PAHO's core functions.

85. PAHO's commitment to equity in health is long-standing and explicit in the Organization's vision, mission, values, and mandates; it is also in line with the Health Agenda for the Americas 2008-2017. The term "inequity" has a moral and ethical dimension, referring to unfair and unjust inequalities that are unnecessary and avoidable. In order to describe a certain situation as inequitable, the cause has to be examined and

judged to be unfair in the context of what is going on in the rest of society. Reducing health inequities is a matter of fairness and social justice. The PAHO Strategic Plan 2014-2019 clearly articulates the commitment of Member States and the Secretariat to *(a)* reduce health inequities; *(b)* reduce the health differentials between and within countries to the lowest level possible; and *(c)* in doing so, create the opportunity for all to attain their full potential in health.

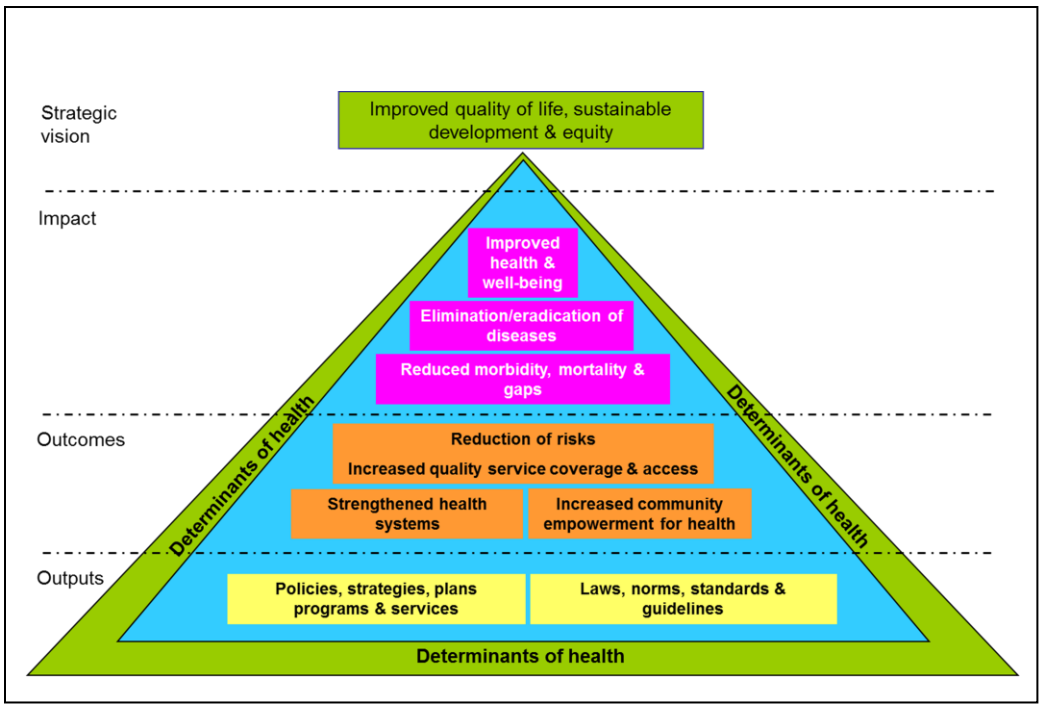
86. Health inequity is at the core of the social determinants of health. The Commission on Social Determinants of Health (CSDH) was established by WHO to address the question of what, if anything, can be done to tackle health inequalities. This Plan follows the proposed set of overarching recommendations and focuses on the **role of the health sector in addressing social determinants of health**. In that regard, the Americas Region proposed the concept of **"Health in All Policies"** as a key State strategy that emphasizes coordinated planning among different sectors and government decision levels with a view to influencing those social determinants that are beyond the direct responsibility of the health sector (e.g., education, employment, housing). The "Health in All Policies" strategy is centered on equity, facilitates progressive realization of the right to health, and generates synergies to advance the sustainable well-being of the population. The Plan identifies specific actions to tackle health inequities, such as those recommended by the CSDH, across all program areas. A **multisectoral approach to health is at the center of the health system effort to address the social determinants of health**, and is therefore a cross-cutting strategic approach for this Plan.

87. **PAHO is committed to advancing universal health coverage as a principal strategic objective in the post-2015 development agenda in the Region of the Americas.** This approach offers the Region the opportunity to consolidate and maintain achievements by Member States in recent years, and at the same time reaffirms health as a key element in sustainable development. This approach will address existing challenges in the Region: it will consolidate advances in maternal and child health and control of communicable diseases, reduce the burden of the chronic diseases epidemic with innovative models of care that include prevention and health promotion, and reduce the gaps in access and utilization of health services.

88. **Building on the progress made in the Region, this Plan aims to move toward a vision focused on healthy living and well-being. Hence, this Plan intends to catalyze changes in the health response in the Region to transcend the traditional disease-oriented approach.** The Plan is influenced by and responds to the global processes addressing the development agenda, as health is central to sustainable development. In the first three years of the Plan, while efforts are made to accelerate MDG achievements, priority will be placed on contributing to and influencing the new development agenda, that is, the post-2015 development agenda and sustainable development goals (SDGs). The last three years of the Plan will fully respond to the new development agenda under the principles of universal health coverage and longer healthy

life. Some of the key issues identified for this Region (Interagency Document - ECLAC, March 2013) are: focus on pending gaps in MDGs, address emerging aspects in line with concurrent changes in the region, and advance a new development model based on equity and environmental sustainability. In this regard, concerns have been raised about the need for a minimum well-being threshold, stronger policies and institutions, better measurement and analytical capacities, and enhanced governance for sustainable development.

Figure 3. Strategic Overview



89. In line with the above, and building upon the experiences and lessons learned, the following **cross-cutting themes** (CCTs) are central to addressing the determinants of health: **gender equity, equity in health, human rights, and ethnicity**. In addition to the social determinants of health, the Plan will apply key public health strategies, such as health promotion, primary health care, and social protection in health. The cross-cutting themes are programmatic approaches to improving health outcomes and reducing inequalities in health, and are applicable to Categories 1 through 6. The public health strategies are overarching approaches to attaining better health for all and by all, with special emphasis on proven public health policies and community-wide interventions.

90. This Plan makes full use of the strategic advantage conferred by some of the most recent elements of planning, programming, and budgeting set out by PAHO, namely the PAHO Budget Policy and the identification of key countries criteria. These elements

inherently recognize a social gradient of health and accordingly seek progressivity in the distribution of resources and in technical cooperation actions, giving more attention to those countries in greater need, yet applying the principle of proportionate universalism. In this regard, and in line with the principles of equity and Pan American solidarity, the Plan identifies **eight priority countries**—Bolivia, Guatemala, Guyana, Haiti, Honduras, Nicaragua, Paraguay, and Suriname—where the Organization commits to place greater emphasis on its technical cooperation to ensure that gaps are closed. This includes making available the necessary human and financial resources to address the various public health challenges faced by these countries.

91. Taking into account that countries and territories in the Region have different health situations and needs, the Plan identifies **target countries and territories** by program area to focus the Organization's technical cooperation on specific public health issues. The target countries and territories are identified at the outcome indicator level based on a comprehensive analysis and in consultation with the Member States. For the purpose of setting baselines and targets, the universe of countries and territories for the Plan is 51: these include the 35 Member States, 4 Associate Member States, and 12 Overseas Territories (the latter comprising 6 United Kingdom Territories, 3 French Departments in the Americas, and 3 Netherlands Antilles Territories). The complete list of countries and territories is included in Annex III.

Impact Goals and Strategic Focus

92. The success of the Plan will be measured by the Organization's contribution to the attainment of the impact goals outlined in Table 1, as measured by their corresponding indicators.

93. If the execution of the Plan is consistent with the Organization's strategic direction, by the end of the planning cycle in 2019 PAHO will be able to show tangible improvements in the health of the population, in particular of those at the lower levels of the social gradient. This, by definition, should produce a reduction of health inequities by narrowing the gaps between and within countries. This implies an explicit approach geared toward health equity and a commitment to measure impact on health equity. In this way, PAHO will contribute to improving the health of the peoples of the Americas.

94. In keeping with the objective of reducing inequities in health, the Plan identifies specific health equity indicators and targets, as the highest level of commitment of the Organization to achieve its strategic agenda in the next six years.

95. Aligned with the impact goals at the global level (as expressed in the WHO 12th GPW 2014-2019), and addressing the specific goals for the Region, Table 1 below outlines the impact goals, indicators, baselines, and targets for the Plan. The rate of

change during the planning cycle will be the basis for measuring the success of the Plan, according to the established impact indicators.

96. The proposed goals and indicators are in agreement with the conclusions of the recent consensus document, "Health in the Post-2015 Agenda: Report of the Global Thematic Consultation on Health" (April 2013). The proposed indicators can be adapted to national and regional contexts and existing conditions to reflect national health needs and priorities.

97. In line with the vision of the Plan, the nine impact goals were chosen to capture and reflect several strategic dimensions of PAHO's work. These include *(a)* PAHO's mandate to improve the health of the people of the Americas and to reduce health inequities between countries; *(b)* PAHO's support to countries in realizing the Health Agenda for the Americas 2008-2017; *(c)* PAHO's commitment to achieve the health targets of the MDGs in the countries of the Region; *(d)* PAHO's commitment to universality, solidarity, and Pan Americanism; *(e)* the need to address the Region's triple burden of communicable diseases, noncommunicable diseases, and injuries; and *(f)* the alignment with WHO's 12th GPW.

Table 1. Impact Goals, Indicators, and Targets* [UNDER REVIEW]

Impact Goals	Impact Indicator	Impact Target
1. Promote health and well-being with equity	Healthy life years and gap	Under development (to be completed by 10 June for Executive Committee)
2. Ensure a healthy start for newborns and infants	Infant mortality rate (IMR)	26% reduction by 2019 compared to the 2014 baseline
	IMR ratio and Health Needs Index (HNI) country quintiles	At least 10% reduction between 2014 and 2019
	IMR Slope Index of Inequality in the HNI intercountry gradient	A reduction of at least 3 infant deaths in excess per 1,000 live births between 2010 and 2019
3. Ensure safe motherhood	Maternal mortality ratio (MMR)	11% reduction by 2019 compared to the 2014 baseline
	MMR and HNI country quintiles	At least 25% reduction between 2014 and 2019
	MMR Slope Index of Inequality in the HNI intercountry gradient	A reduction of at least 18 maternal deaths in excess per 100,000 live births between 2010 and 2019
4. Reduce mortality due to poor quality of health care	Amenable mortality rate (AMR)	9% reduction by 2019 compared to the 2014 baseline
	AMR Ratio and HNI country quintiles	No more than 6% increase between 2010 and 2019

Impact Goals	Impact Indicator	Impact Target
	AMR Slope Index of Inequality in the HNI intercountry gradient	No more than 8 preventable deaths in excess per 100,000 population between 2010 and 2019
5. Improve health of the adult population with an emphasis on NCDs and risk factors	Premature noncommunicable mortality rate (PNMR)	8% reduction by 2019 compared to 2014 baseline
	PNMR Ratio and HNI country quintiles	No more than 14% increase between 2014 and 2019
	PNMR Slope Index of Inequality in the HNI intercountry gradient	No more than 18 premature deaths in excess due to NCDs per 100,000 population between 2010 and 2019
6. Reduce mortality due to communicable diseases	Mortality rate due to AIDS (AIDSMR)	15% reduction by 2019 compared to the 2014 baseline
	Number of deaths caused by dengue	30% reduction by 2019 compared to 2012
	Mortality due to tuberculosis	24% reduction by 2019 compared to 2014
	Mortality due to malaria	75% reduction in deaths compared to 2011
7. Curb premature mortality due to violence and injuries by tackling major risks of adolescents and young adults (15-24 years of age) by	Homicide rate	6% reduction by 2019 compared to the 2014 baseline
	Suicide rate	No increase by 2019 compared to 2014
	Deaths due to road traffic injuries	No increase or 1% reduction by 2019 compared to the 2014 baseline
8. Eliminate priority communicable diseases in the Region	Number of countries and territories that have eliminated mother-to-child transmission of HIV and congenital syphilis	16 countries and territories by 2019
	Number of countries that have eliminated onchocerciasis	4 countries by 2019
	Number of countries that have eliminated leprosy at first subnational level	23 countries by 2019
	Number of countries that have interrupted Chagas transmission by the main vector in the entire territory or territorial units at risk	21 endemic countries by 2019
	Number of endemic countries that have eliminated malaria	At least 3 of the 6 endemic countries (ARG, DOR, ECU, HON, MEX, PAR)
	Number of countries with zero human cases of dog-transmitted rabies	35 countries by 2019

Impact Goals	Impact Indicator	Impact Target
9. Prevent death, illness, and disability arising from emergencies	Percentage of major acute emergencies in which the crude mortality rate returns to accepted baseline levels within 3 months	70% of emergencies (reported using the internationally agreed database)

Note: These targets represent the collective regional commitment. Each country will determine its own targets.

98. In addition to the impact goals, indicators, and targets, the Plan contains **strategic areas of focus** to guide its implementation, as follows:

I. **Reducing the burden of communicable diseases**, including HIV/AIDS and sexually transmitted infections (STIs); tuberculosis; malaria and other vector-borne diseases; neglected, tropical, and zoonotic diseases; vaccine-preventable diseases; and viral hepatitis.

II. **Reducing the burden of noncommunicable diseases**, including cardiovascular diseases, cancers, chronic lung diseases, diabetes, and mental health disorders, as well as disability, violence, and injuries, through health promotion and risk reduction, prevention, treatment, and monitoring of noncommunicable diseases and their risk factors.

III. **Promoting good health at key stages of life,** taking into account the need to address the social determinants of health (societal conditions in which people are born, grow, live, work, and age), and implementing approaches based on gender equality, ethnicity, equity, and human rights.

IV. **Strengthening health systems** with a focus on governance for social protection in health; strengthening legislative and regulatory frameworks and increasing financial protection for progressive realization of the right to health; organizing people-centered, integrated service delivery; promoting access to and rational use of quality, safe, and effective health technologies; strengthening information systems and national health research systems; promoting research for integrating scientific knowledge into health care, health policies, and technical cooperation; facilitating transfer of knowledge and technologies; and developing human resources for health.

V. **Reducing mortality, morbidity, and societal disruption resulting from epidemics, disasters, conflicts, and environmental and food-related emergencies** by focusing on risk reduction, preparedness, response, and recovery activities that build resilience and use a multisectoral approach to contribute to health security.

VI. **Fostering and implementing the organizational leadership and corporate services** that are required to maintain the integrity and efficient functioning of the Organization, enabling it to deliver effectively on its mandates.

Organization of the Plan

99. In line with WHO's 12th GPW 2014-2019, the Plan is organized in six categories and 31 program areas, as outlined in Table 2. The details for each category and its respective program areas are provided in the sections that follow. For each category, the document sets forth the scope; context, broken down by program areas; key stakeholders' analysis; strategies for technical cooperation; and cross-cutting themes and strategic approaches in health, which include opportunities for inter-programmatic collaboration and coordination. This is followed by tables presenting outcomes and outcome indicators for each program area within the corresponding category. For each outcome indicator a list of baseline and target countries is defined. Unless otherwise stated, the baseline is defined as 2012.

Table 2. Categories and Program Areas

Category	Program Areas
1. Communicable Diseases	1.1 HIV/AIDS and STIs 1.2 Tuberculosis 1.3 Malaria and other Vector-borne Diseases (including Dengue and Chagas) 1.4 Neglected, Tropical, and Zoonotic Diseases 1.5 Vaccine-Preventable Diseases (including Maintenance of Polio Eradication) 1.6 Viral Hepatitis (subject to budget confirmation)
2. Noncommunicable Diseases and Risk Factors	2.1 Noncommunicable Diseases and Risk Factors 2.2 Mental Health and Substance Use Disorders 2.3 Violence and Injuries 2.4 Disabilities and Rehabilitation 2.5 Nutrition
3. Determinants of Health and Promoting Health throughout the Life Course	3.1 Women, Maternal, Newborn, Child, and Adolescent Health, and Sexual and Reproductive Health 3.2 Aging and Health 3.3 Gender Equity, Equity in Health, Human Rights, and Ethnicity Mainstreaming 3.4 Social Determinants of Health 3.5 Health and the Environment
4. Health Systems	4.1 Health Governance and Financing; National Health Policies, Strategies, and Plans 4.2 People-Centered, Integrated, Quality Health Services 4.3 Access to Medical Products and Strengthening of Regulatory Capacity

Category	Program Areas
	4.4 Health Systems Information and Evidence 4.5 Human Resources for Health
5. Preparedness, Surveillance, and Response	5.1 Alert and Response Capacities 5.2 Epidemic- and Pandemic-Prone Diseases 5.3 Emergency Risk and Crisis Management 5.4 Food Safety 5.5 Outbreak and Crisis Response
6. Corporate Services/Enabling Functions	6.1 Leadership and Governance 6.2 Transparency, Accountability, and Risk Management 6.3 Strategic Planning, Resource Coordination, and Reporting 6.4 Management and Administration 6.5 Strategic Communications

Note: Please see Draft PAHO Program and Budget 2014-2015 (document CE152/11) for details regarding budgeting for polio and for outbreak and crisis response, which are separate budget segments per WHO budgeting practice.

Priority Setting

100. The 31 program areas established in the Plan represent the priorities for the Organization during period covered by the Plan. These program areas were identified by Member States as part of the development of WHO's 12th GPW 2014-2019, with further consultation to reflect specific regional priorities. In addition, the Plan establishes a prioritization framework to guide the allocation of all resources available to the Pan American Sanitary Bureau (PASB), including human and financial resources, and for targeting resource mobilization to implement the PAHO Strategic Plan 2014-2019 (SP 14-19). This framework is in line with the principles of the PAHO Budget Policy and with the PAHO Results-based Management framework. General principles, including criteria and a scientific method, are set out to guide the application of this framework in an objective manner. The criteria and method will be applicable across the program areas to identify priority levels (1, 2, and 3). The complete framework, including the criteria and methodology, can be found in Annex II.

101. The results of the prioritization exercise will be included in the Plan to inform decision making.

Table 3. Results of Prioritization Framework

(UNDER DEVELOPMENT - RESULTS TO BE INCLUDED AFTER CONSULTATION WITH COUNTRIES)

VI. Categories, Program Areas, and Outcomes

Category 1 - Communicable Diseases

Reducing the burden of communicable diseases, including HIV/AIDS and sexually transmitted infections; tuberculosis; malaria and other vector-borne diseases; neglected, tropical, and zoonotic diseases; vaccine-preventable diseases; and viral hepatitis.

Scope

102. Prevalent infectious diseases, as well as newly reemerging communicable diseases, result in significant morbidity and mortality in the Region of the Americas, which can dramatically increase during times of outbreaks (e.g., dengue). These diseases are a crisis for the developing world, exacerbating poverty, inequities, and ill health; they also present substantial challenges for developed countries by placing an unnecessary burden on health and social systems, national security, and the economy. This category covers the following program areas: *(a)* HIV/AIDs and sexually transmitted infections; *(b)* tuberculosis; *(c)* malaria and other vector-borne diseases (e.g., dengue and Chagas); (d) neglected, tropical, and zoonotic diseases; *(e)* vaccine-preventable diseases (including maintenance of polio eradication); and *(f)* viral hepatitis.

Context

1.1 HIV/AIDs and Sexually Transmitted Infections

103. In 2011 an estimated 1.4 million people were living with HIV in Latin America and 230,000 in the Caribbean. The Region has made significant progress in reducing new HIV infections and AIDS-related mortality. Approximately 83,000 people were newly infected with HIV in Latin America in 2011 compared to 93,000 in 2001, and AIDS-related deaths declined by 10%, from 60,000 to 54,000. During the same period the Caribbean had a decline in new infections from 22,000 to 13,000, and a 50% reduction in AIDS-related deaths. Significant progress was also made in expanding access to antiretroviral therapies (ART); the estimated treatment coverage in the LAC Region was 68% in 2011. However, most countries have not yet achieved universal access. The persistent verticality and financial vulnerability of the HIV response, in particular treatment programs, threatens efforts to maintain these achievements and cover the remaining gaps toward universal access. Key populations, including men who have sex with men (MSM), sex workers, and transgender populations, remain disproportionately affected by the epidemic. Stigma and discrimination, as well as limited capacity of the health sector to adequately provide services for these groups, continue to be major challenges for development of an adequate response. Also, progress toward strengthening of strategic information systems and their integration in health information systems has been inconsistent, and this continues to hamper evidence-based programming and

monitoring of progress. The LAC Region was the first to formally commit to the elimination of mother-to-child transmission of HIV in a dual approach embracing the existing commitment for elimination of congenital syphilis.

104. The HIV-related technical cooperation strategy has four priorities or flagships: *(a)* strengthening and expanding treatment programs through the promotion of evidence-based technical and programmatic options based on public health principles and articulated across the five pillars of the Treatment 2.0 Initiative; *(b)* elimination of mother-to-child transmission of HIV and congenital syphilis through the promotion and strengthening of integration of HIV, sexual and reproductive health, and maternal, neonatal, and child health (MNCH) services, early enrollment in antenatal care, and early detection and treatment and for pregnant women infected with HIV or syphilis and exposed infants; *(c)* advocacy for policy and priority setting, fostering of a supportive environment for outreach to key populations, addressing stigma and discrimination, promotion of a human rights-based approach to the HIV response, development of packages of services (blueprints), capacity building of service providers, and fostering of community involvement; and *(d)* strengthening of health information systems, promotion and support for a longitudinal approach through case-based surveillance and continuum of care monitoring, analysis and dissemination of regional information, and implementation of a regional strategy for prevention, surveillance, and monitoring of HIV drug resistance. An emphasis on health system strengthening and primary health care is incorporated in all the flagships.

105. Annually, an estimated 89 million new cases of sexually transmitted infections, including syphilis, chlamydia, gonorrhea, and human papillomaviruses (HPV), occur among people aged 15-49 years in the Region. In addition to causing mortality directly, these STIs contribute to a range of negative health outcomes, including infertility, stillbirths, ectopic pregnancy, and cancers. Some STI, in particular those causing genital ulcerations, increase the risk of acquisition or transmission of HIV infection. Data limitations and lack of comprehensive national strategies for STI prevention, diagnosis, and treatment compromise the capacity of the Region to adequately target and address STIs.

106. The scope and performance of STI control efforts in the Region are variable, and PAHO's support for strengthening of national programs is critical. PAHO's technical support will focus on strengthening the normative and strategic information functions of the national programs. This will include strengthening the Gonococcal Antimicrobial Surveillance Programme (GASP) and providing support to countries for development or updating of national strategies and guidelines for STI prevention and management based on the data generated by GASP and other STI surveillance, and on available global and regional normative guidance.

1.2 Tuberculosis

107. Major progress has been made in the Americas since the implementation of the Stop TB Strategy, which allowed expansion of diagnosis and treatment of both sensitive and resistant tuberculosis, whether or not associated with HIV infection. TB incidence is now declining in the Americas, but at a rate of only 3% per year. For the Americas in 2011, WHO estimated 268,000 new TB cases and 21,000 deaths due to TB, excluding those co-infected with HIV. During that year 218,000 new TB cases were reported. Compared with the estimates, the cases reported represented a case detection rate of 81%.

108. The TB epidemic is intensified by poverty, migration, and other social vulnerabilities. The rise of NCDs, including diabetes and tobacco-associated disease, means that more immune-compromised individuals are at risk of falling ill with tuberculosis and adds to the social risks already present. These conditions converge in slum areas of the cities, where existing social inequities limit access to health services, especially for women, children, elders, and especially vulnerable populations (e.g., drug users, homeless, mentally ill, ethnic minorities, etc.). There is a need to integrate basic health programs and services to facilitate access to early TB diagnosis and treatment. Coupled with increasing community, civil society, and private sector engagement, this can ensure more effective use of new diagnostics and medicines now available or in the pipeline for the prevention and treatment of TB, MDR-TB, and HIV-associated TB (TB/HIV).

109. PAHO's normative, surveillance, technical support, and partnership roles are crucial in controlling the TB epidemic. The TB Regional Program focuses on strengthening national capacity to implement the Global TB Strategy in countries, which seeks to reach vulnerable populations through the introduction of national frameworks for TB control. The program will also update and consolidate emerging policies and technical guidance and adapt them to national contexts. As a result, technical cooperation to support national TB programs will reinforce the use of rapid diagnostic tools and improved laboratory practices, strengthened delivery of care for MDR-TB patients, integrated community-based management of TB, adequate access to new guidelines and tools, increased access to quality first- and second-line drugs, and strengthened surveillance systems complemented by improved analysis and use of data.

1.3 Malaria and Other Vector-borne Diseases

110. Mortality rates for malaria have fallen by more than 25% globally since 2000. In the Americas, mortality decreased by 67% between 2000 and 2011, while morbidity (i.e., total confirmed cases) declined by 58%. However, to reach the goals set for 2015, a massive extension of access to malaria prevention, especially through sustainable vector control, and to quality-assured diagnostic testing and effective antimalarial treatment is

required. There is a risk of malaria resurgence due to decreasing international funding for prevention and control, as well as to resistance to artemisinin and insecticides. This demands sustained strategic investments from both partners and countries in which malaria is endemic. In addition, strengthened surveillance systems are needed to target limited resources appropriately and to evaluate the progress and impact of control measures.

111. Support to malaria-endemic countries will include capacity building for malaria prevention, control, and elimination, strengthening surveillance, and identifying both threats and new opportunities for malaria control and elimination. Aligned with the global technical strategy for malaria control and elimination (2016-2025), PAHO's work in this area will guide countries and other stakeholders in sustaining the successes of the past decade and update policy and technical guidance on vector control, diagnostic testing, and antimalarial treatment. In addition, PAHO reinforces its strong commitment and emphasis on preventing reintroduction of local transmission in areas previously declared malaria-free.

112. Dengue is an endemic disease with epidemic cycles associated with social determinants such as population growth, poverty, and limited access to basic services. Since 2003, 45 countries and territories of the Americas have reported 8.6 million dengue cases and 4,400 deaths. Dengue is a disease that historically causes severe negative political, economic, and social impacts in countries. Currently, technical cooperation is directed toward strengthening national capacities for comprehensive surveillance, patient care, and early detection, preparedness, and control of outbreaks within the framework of the Integrated Management Strategy for Dengue Prevention and Control (IMS-Dengue) and the WHO Global Strategy 2012-2020.

113. Chagas is the most prevalent tropical communicable disease in Latin America, with an annual incidence of 28,000 cases. It affects an estimated 8 million people and causes on average 12,000 deaths per year. More needs to be done to prevent this disease from further expanding and to properly find, diagnose, and treat already infected patients. Furthermore, significant intercountry coordination and technical work will be required to sustain the successes achieved in eliminating this vector-borne disease from many endemic territories and to properly maintain quality blood screening in all the countries. The Strategy and Plan of Action for Chagas Disease Prevention, Control and Care, supported by subregional intercountry initiatives, has been effective and capable of reducing morbidity, mortality, and human suffering, as well as efficient in saving countries' resources by reducing direct and indirect costs associated with this disease.

1.4 Neglected, Tropical, and Zoonotic Diseases

114. In Latin America and the Caribbean, neglected infectious diseases (NIDs) affect vulnerable poor populations, including indigenous and Afro-descendant groups as well as people living in rural and periurban areas who frequently have difficulties accessing health services. It is estimated that the Region of the Americas has 8.8% of the global NIDs, which is linked to the 40% of the LAC population (approximately 200 million people) living in poverty. Certain NIDs are also reported in the United States and Canada, but with generally lower prevalence. The PAHO regional "road map" for five NIDs provides guidelines for accelerating the work to overcome the impact of neglected and tropical diseases in LAC and sets out a timetable for the control and, where appropriate, elimination of 12 specific diseases. As part of this strategy, the donation of drugs and the support of different partners has made it feasible to implement large-scale preventive chemotherapy and adequate case treatment; this is already having a positive and measurable impact on affected countries. Sustaining the current momentum for tackling these diseases requires not only commodities and financing but also political support. PAHO will focus on expanding preventive, innovative, and intensified disease management and increasing access to essential medicines for neglected, tropical, and zoonotic diseases. Additionally, strengthening national capacity for disease surveillance, quality and timely monitoring of progress, and documentation and certification/verification of the elimination of selected diseases will remain an area of focus.

115. Zoonoses occur in all countries of the Region and mainly affect vulnerable human populations with limited access to quality health services, as well as those exposed to animals and animal products in poor sanitary conditions. As most zoonotic diseases are neglected, data on the burden of disease are limited. However, current evidence indicates that in the Americas, 70% of the recorded infectious disease events are zoonoses and/or communicable diseases common to human and animals. Most zoonoses of production animals are endemic in the Region, while zoonoses of companion and wild animals are being detected with greater frequency; one example is the spread of human rabies transmitted by hematophagous bats. Despite widespread elimination of human rabies transmitted by dogs in the Region, pockets of disease remain. PAHO/WHO interventions to prevent these diseases in humans are multisectoral and require effective and integrated surveillance and control activities on the part of veterinary and food inspection programs, coordinated with the public health sector, as well as the engagement of nongovernmental organizations, local governments, and communities for the early detection and treatment of human cases.

1.5 Vaccine-Preventable Diseases

116. The Region has been recognized for its global leadership in immunizations and for paving the road for innovation and further advances in this area. The vast array of program achievements includes the elimination of smallpox, polio, measles, and rubella; immunization coverage rates that are among the highest in the world; rapid advances in the introduction of new vaccines; leadership in promoting evidence-based decision-making; the procurement of quality affordable vaccines through the PAHO Revolving Fund; the development and use of computerized immunization registries; and the expansion of Vaccination Week in the Americas to World Immunization Week (in 2012). Finally, the immunization program has effectively evolved from a program directed to children to one that targets the entire family.

117. Nonetheless, much work remains to be done to maintain these achievements, to address the unfinished agenda of expanding the benefits of immunization, and to face several new and emerging challenges.

118. The high average coverage levels for the Region hide sharp inequalities within and between countries. Haiti remains the only country in the Region that has yet to eliminate neonatal tetanus as a public health problem, and the country lacks a consolidated and strong national immunization program. The process of documentation and verification of measles and rubella in the Region has unmasked important problems with vaccine-preventable disease (VPD) surveillance; these problems need to be addressed in order to maintain the Region's status as free of those VPDs already eliminated. Sustainable introduction of new vaccines (e.g., malaria and dengue) poses a challenge to immunization programs, requiring substantial budget increases and a significant expansion of the cold chain. Haiti has also experienced challenges with the availability and use of vaccines to address serious and complex public health problems, such as cholera.

119. Finally, after more than 20 years without cases, the Region is still at risk of receiving an importation of wild poliovirus or of a circulating vaccine-derived poliovirus (cVDPV). The Plan of Action to maintain the Americas free of poliomyelitis provides a framework for the Region to remain free of poliomyelitis during the pre- and post-elimination eras, as well as during the transition between these eras. The Plan articulates a comprehensive strategy to enhance all aspects of community protection and epidemiologic surveillance.

1.6 Viral Hepatitis (inclusion of this program area is under review, pending confirmation of budget)

120. Approximately one-third of the world's population has had contact with or has contracted infection with the hepatitis B virus (HBV). In the Americas, the estimated prevalence of hepatitis B infection ranges from below 2% to 4%. Additionally, an estimated 7 million to 9 million adults in LAC are infected with the hepatitis C virus (HCV). An estimated 65% to 80% of hepatitis B and around 55% of hepatitis C infections in health workers in Latin America and the Caribbean are due to needlestick injuries. Super-infection with hepatitis D also occurs in the Region, particularly affecting indigenous peoples in the Amazonian region who are at genetic risk. Also, despite mainly low prevalence rates, outbreaks of hepatitis A and E have been reported in some countries, pointing to the need for better data and surveillance of these groups of diseases. Hepatitis A clinical cases are shifting from young to middle-aged and older people, raising the potential for worse clinical scenarios and higher fatalities. Persons with HIV infection and other immune-compromised groups (such as pregnant women and people with chronic conditions) are disproportionately affected by viral hepatitis, which can cause serious liver complications and increase the risk of death.

121. The Americas has been acknowledged for its proactive and successful initiatives in the use of vaccines against hepatitis B. More recently, recommendations for one-dose vaccination against hepatitis A are also being given priority. Blood screening for hepatitis B and C virus has been encouraged in the Region, with success, and health professionals have been trained in the prevention of needlestick accidents. Still, just a few countries of the Americas currently have a public health structure that officially responds to the health needs generated by these infections and diseases. After the passage of Resolution WHA63.18 in May 2010, PAHO responded immediately and has been working with the countries to develop a regional strategy aligned with the WHO Framework for Global Action against viral hepatitis.

122. The PAHO proposal focuses on education and advocacy, surveillance and monitoring, diagnosis, case management and treatment, and priority research.

Key Stakeholders' Analysis

123. The surveillance, promotion, prevention, diagnosis, treatment, control, and elimination of communicable diseases will be achieved through joint efforts with new and existing partners, both within and outside the health sector. PAHO will continue to foster collaborations with various UN agencies, major foundations, WHO collaborating centers, multilateral and bilateral agencies, scientific institutions, and other key strategic partners that share the same vision of reducing the burden of communicable diseases at the regional and global level. These efforts will utilize available alliance-building tools

such as technical cooperation agreements, interagency coordinating committees (ICC), public-private partnerships, technical cooperation among countries (TCC), letters of agreement, and so on.

124. The current panorama of strategic partners includes: Bill and Melinda Gates Foundation (BMGF), Caribbean Public Health Agency (CARPHA), Canadian International Development Agency (CIDA), Canadian Society for International Health (CSIH), Centers for Disease Control and Prevention (CDC), Development Bank of Latin America (CAF), Food and Agriculture Organization of the United Nations (FAO), Oswaldo Cruz Foundation (Fiocruz), GAVI Alliance, Global Alliance for Rabies Control (GARC), Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Green Light Committee (GLC) Initiative, Inter-American Development Bank (IDB), Inter-American Institute for Cooperation on Agriculture (IICA), International Association of Providers of AIDS Care (IAPAC), Joint United Nations Programme on HIV/AIDS (UNAIDS), Measles & Rubella Initiative, Common Market of the South (MERCOSUR), Regional International Organization for Plant Protection and Animal Health (OIRSA), Program for Appropriate Technology in Health (PATH), Public Health Agency of Canada (PHAC), Sabin Vaccine Institute (SVI), Spanish Agency for International Development Cooperation (AECID), Task Force for Global Health (TFGH), United Nations Children's Fund (UNICEF), United States Agency for International Development (USAID), United States President's Emergency Plan for AIDS Relief (PEPFAR), United States Department of Health and Human Services (HHS), World Organisation for Animal Health (OIE), World Society for the Protection of Animals (WSPA).

Strategies for Technical Cooperation

125. Supporting national capacity building and self-sustainability:

(a) Provide technical cooperation and support to Member States that is aligned with PAHO/WHO Governing Bodies' mandates and resolutions, global and regional frameworks, and evidence-based recommendations provided by recognized regional strategic and technical advisory groups.

(b) Prioritize vulnerable populations and high-risk groups in the technical cooperation provided.

(c) Scale up effective interventions focused on the surveillance, promotion, prevention, diagnosis, treatment, control, and elimination of communicable diseases.

(d) Underscore national and local capacity building at all levels, as well as effective intercountry collaboration, in order to achieve a sustainable and positive impact on health and social programs.

(e) Promote and support the adoption and use of newly developed, accessible, and effective technology that accelerates the efforts to reach health goals in the countries and the Region.

(f) Develop and implement effective strategies for sunsetting and sustainability of related programs at national level, such as moving from focused support to select priority countries to higher-level regional technical cooperation.

126. Developing norms and standards:

(a) Build upon PAHO's technical expertise, which is grounded in scientific evidence and applied knowledge, in setting and adapting regional norms and standards.

(b) Work in collaboration with Member States to generate evidence for developing regional guidelines, tools, and methodologies.

(c) Foster stakeholder buy-in and country ownership of regional norms and standards that are established in the area of communicable diseases, facilitating their widespread dissemination, use, and adaptation at all levels.

(d) Ensure that elements of supervision, monitoring, and evaluation are incorporated into programs at all levels.

127. Shaping the research agenda:

(a) Identify key health-related challenges in need of operational or knowledge-based answers.

(b) Promote operational research and the appropriate use of the results to reduce morbidity, mortality, and the burden caused by infectious diseases in the Region.

(c) Support the establishment of mechanisms for the collection, analysis, preparation, dissemination, and use of strategic information to contribute to the body of knowledge on best practices for the surveillance, prevention, control, and elimination of communicable diseases.

Cross-Cutting Themes and Strategic Approaches in Health

128. The surveillance, promotion, prevention, treatment, diagnosis, control, and elimination of communicable diseases in the Americas present many opportunities for inter-programmatic work to ensure an integrated approach in program development and delivery. These transversal collaborations occur among the program areas of Category 1, as well as among the various categories. Furthermore, all programmatic areas within Category 1 are closely related to the work performed in Category 5 (preparedness, surveillance, and response), specifically with respect to efforts to provide an integrated

approach to the prevention, early detection, immediate response, and reporting of communicable diseases that fall under the 2005 International Health Regulations.

129. In the area of HIV/AIDs and STIs, work contributes to and benefits from Category 2 (Noncommunicable Diseases and Risk Factors); Category 3 (Determinants of Health and Promoting Health throughout the Life Course), because the prevention of mother-to-child transmission will provide opportunities for access to HIV and other health services for women at various stages of life; Category 4 (Health Systems), through improved health infrastructure and increased access to treatment; and Category 5 (Preparedness, Surveillance, and Response).

130. The area of tuberculosis is linked to Categories 2 and 4. In the case of linkage to Category 2, individuals with certain noncommunicable diseases, such as diabetes, may have underactive immune systems that increase their risk of contracting tuberculosis. Similarly, in the case of linkage to Category 4, the foundation of an efficient TB program relies on the adequate functioning of the primary health care system to diagnose and treat patients, followed by a selective but efficient referral and counter-referral system.

131. The program area of neglected, tropical, and zoonotic diseases is linked to Category 3, as interventions to prevent and treat schistosomiasis, trachoma, soil-transmitted helminths, and other neglected diseases will have a positive impact on maternal and child health outcomes.

132. In the area of vaccine-preventable diseases, there are opportunities for inter-programmatic work with Category 2, to address issues related to HPV and hepatitis B vaccines; Category 3, where the administration of traditional and new vaccines contributes to improved health throughout the life course; Category 4, as immunization is a vehicle for reaching vulnerable populations with other health interventions and also provides opportunities to link immunization registries, birth registration, and other health statistics into a comprehensive health information system; and Category 5, for the close monitoring of VPD surveillance to ensure timely detection and response to outbreaks in the Region and for the strengthening of laboratory capacity.

133. Within Category 1, work on viral hepatitis is closely tied to efforts on HIV/AIDs and STIs because of the issue of co-infection; strategies regarding blood safety, injection safety, and promotion of safer sex practices also relate to both areas. Within Category 2, hepatitis is more likely to occur among immune-compromised patients, including chronic disease carriers. This program area also requires opportunities for inter-programmatic collaboration with Categories 3, 4, and 5.

134. The cross-cutting themes of gender equity, equity in health, human rights, and cultural diversity are incorporated into Category 1 to improve health outcomes.

(a) Interventions to combat communicable diseases are tailored to respond to issues of gender and cultural diversity by building upon an understanding of men and women across all ages, of their cultural heritages, and of the factors that influence their health situation. It also includes the collection and reporting of data disaggregated by age, sex, and other relevant variables.

(b) The focus on the prevention, treatment, and control of communicable diseases, particularly in areas of greatest need, supports ideals of equity in health and poverty reduction to reach vulnerable populations with integrated health interventions that prevent extreme misfortune when illness occurs.

(c) A human rights approach is particularly relevant in the program areas of HIV/AIDs and STIs; tuberculosis; neglected, tropical, and zoonotic diseases; and viral hepatitis. Careful attention must be paid to promoting interventions that combat stigma and discrimination.

135. Strategic approaches in health, namely social determinants, primary health care, health promotion, and social protection, are strongly integrated into the work of Category 1.

(a) Social determinants of health, such as population growth, poverty, migration, inadequate living conditions, and the lack of basic services, are factors that impede efforts to prevent, treat, and control communicable diseases (neglected, tropical, and zoonotic diseases, for instance). Social determinants thus contribute to negative health outcomes that accentuate inequities in health. Interventions implemented by the program areas will build upon existing best practices to address social determinants head-on for improved health outcomes.

(b) Many interventions aligned with the work of the various program areas occur at the primary health care level and provide an entry point for families to access other quality health services (e.g., immunizations), as well as additional opportunities to receive health education. Incorporation of these interventions at the PHC level also facilitates access to early diagnosis and treatment of communicable diseases (e.g., malaria and TB).

(c) Prevention of communicable diseases is aligned with the principles of social protection in health by limiting exposure to infectious agents that may lead to sickness, disability, or increased poverty, particularly among marginalized and vulnerable populations.

Category 1. Communicable Diseases

Program Areas and Outcomes

(BASELINES AND TARGETS UNDER REVIEW, PENDING NATIONAL CONSULTATIONS)

1.1 HIV/AIDS and Sexually Transmitted Infections

Outcome	Ind. #	Outcome Indicators	Baseline 2012[1]	Target 2019 (baseline +)
OCM 1.1 Increased access to key interventions for HIV and STI prevention and treatment	OCM 1.1.1	Number of countries that have 80% coverage of antiretroviral therapies (eligible population)	2 CUB, GUY	12 ARG, BRA, CHI, COR, DOR, ECU, MEX, NIC, PAR, PER
	OCM 1.1.2	Number of countries and territories with at least 95% coverage of HIV prophylaxis and syphilis treatment in pregnant women and in children	0	15 ANU, BAH, BAR, BER, BLZ, CAN, CHI, CUB, DOM, GRA, GUY, PER, SAV, SCN, USA

1.2 Tuberculosis

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 1.2 Increased number of tuberculosis patients successfully diagnosed and treated	OCM 1.2.1	Cumulative number of TB bacteriologically confirmed patients successfully treated in programs that have adopted the WHO recommended strategy since 1995	1.34 million	2.3 million
	OCM 1.2.2	Annual number of tuberculosis patients with confirmed or presumptive multidrug-resistant tuberculosis (MDR-TB), including rifampicin-resistant cases, placed on MDR-TB treatment worldwide	3,473	4,410
	OCM 1.2.3	Percentage of new TB patients diagnosed in relation to the WHO estimated cases from 1995 to 2011	81%	90%

[1] The baseline year is 2012 or the year for which the most recent data are available. The year is indicated for those indicators without 2012 data.

1.3 Malaria and other vector-borne diseases

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 1.3 Increased country capacity to develop and implement comprehensive plans, programs, or strategies for the surveillance, prevention, control, and/or elimination of malaria and other vector-borne diseases	OCM 1.3.1	Percentage of confirmed malaria cases in the public sector receiving first-line antimalarial treatment according to national policy (based on PAHO/WHO recommendations)	85%	95%
	OCM 1.3.2	Number of countries with installed capacity to eliminate malaria	6 ARG, COR, ECU, ELS, MEX, PAR	13 BLZ, DOR, GUT, HAI, HON, NIC, PAN
	OCM 1.3.3	Number of countries with installed capacity for the management of all dengue cases	3 BRA, ELS, MEX	17 ARG, BOL, COL, COR, DOR, ECU, HON PAN, PAR, PER, PUR, NIC, VEN, GUT
	OCM 1.3.4	Number of countries and territories where the entire endemic territory or territorial unit has a domestic infestation index (by the main triatomine vector species or by the substitute vector, as the case may be) of less than or equal to 1%	14 ARG, BLZ, BOL, BRA, CHI, COR, ELS, GUT, HON, MEX, NIC, PAR, PER, URU	21 COL, ECU, FRG, GUY, PAN, SUR, VEN

1.4 Neglected, tropical, and zoonotic diseases

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 1.4 Increased country capacity to develop and implement comprehensive plans, programs, or strategies for the surveillance, prevention, control, and/or elimination of neglected, tropical, and zoonotic diseases	OCM 1.4.1	Number of endemic countries with annual increases in diagnosed cases and etiological treatment as a result of an increase in the quality and coverage of medical attention for human leishmaniasis	0	12 ARG, BOL, BRA, COL, COR, GUT, HON, NIC, PAN, PAR, PER, VEN
	OCM 1.4.2	Number of endemic countries with a case detection system for leprosy among vulnerable populations	18 COL, COR, CUB, ECU, ELS, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PER, SAL, SUR, TRT, URU	24 ARG, BOL, BRA, DOR, PAR, VEN
	OCM 1.4.3	Number of endemic countries having achieved the recommended target coverage of population at risk of lymphatic filiariasis	1 HAI	4 BRA, DOR, GUY

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
	OCM 1.4.4	Number of endemic countries having achieved the recommended target coverage of population at risk of onchocerciasis	1 BRA	2 VEN
	OCM 1.4.5	Number of endemic countries having achieved the recommended target coverage of population at risk of trachoma	0	3 BRA, COL, GUT
	OCM 1.4.6	Number of endemic countries having achieved the recommended target coverage of population at risk of schistosomiasis	0	2 BRA, COL
	OCM 1.4.7	Number of endemic countries having achieved the recommended target coverage of population at risk of soil-transmitted helminths	3 BLZ, MEX, NIC	14 BRA, BOL, COL, DOR,ELS, ECU, GUY, HAI, HON, PAR, PER
	OCM 1.4.8	Number of countries with established capacity and effectiveness processes to eliminate human rabies transmitted by dogs	28 ANI, ARG, BAH, BAR, BLZ, CAN, CHI, COL, COR, CUB, DOM, ECU, ELS, GRA, GUY, JAM, MEX, NIC, PAN, PAR, SAL, SAV, SCN, SUR,TRT, URU, USA, VEN	35 BOL, BRA GUT, HAI, DOR, HON, PER,

1.5 Vaccine-preventable diseases

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 1.5 Increased vaccination coverage for hard-to-reach populations and communities and maintenance of control, eradication, and elimination of vaccine-preventable diseases	OCM 1.5.1	Regional average coverage with three doses of diphtheria, tetanus, and pertussis-containing vaccine	92%	94%
	OCM 1.5.2	Number of countries and territories with reestablishment of endemic transmission of measles and rubella virus	0	0
	OCM 1.5.3	Number of countries and territories that have introduced one or more new vaccines	34 ARG, ARU, BAH, BAR, BER, BOL, BON, BRA, CAN, CAY, CHI, COL, COR, CUR, DOR, ECU, ELS, FRG, GUA, GUT, GUY, HON, MAR, MEX, NIC, PAN, PAR, PER, SAB, STA, TRT, URU, USA,VEN	51 ANU, ANI, BLZ, BVI, CUB, DOM, DSM, GRA, HAI, JAM, MON, PUR, SAL, SAV, SCN, SUR, TCA
	OCM 1.5.4	Number of countries and territories reporting cases of paralysis due to wild or circulating vaccine-derived poliovirus (cVDPV) in the preceding 6 months.	0	0

1.6 Viral hepatitis (inclusion of this program area is subject to budget confirmation)

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 1.6 Increased countries' capacity to improve surveillance, prevention, diagnosis, treatment, monitoring, and control of viral hepatitis	OCM 1.6.1	Number of countries provided with integrated Hepatitis surveillance with emphasis on high risk groups according to PAHO/WHO guidelines. (OCM)	2 ARG, BRA	TBD

Category 2 - Noncommunicable Diseases and Risk Factors

Reducing the burden of noncommunicable diseases, including cardiovascular diseases, cancers, chronic lung diseases, diabetes, and mental health disorders, as well as disability, violence, and injuries, through health promotion and risk reduction, prevention, treatment, and monitoring of noncommunicable diseases and their risk factors.

Scope

136. PAHO, together with partner organizations in various sectors, will address the burden of noncommunicable diseases with a particular focus on cardiovascular diseases, cancer, diabetes, lung disease, and chronic renal disease, as well as on the common risk factors of tobacco use, harmful use of alcohol, unhealthy diet, physical inactivity, and obesity. In the NCD response, PAHO will also focus on nutrition and other NCD-related conditions, including mental health, violence and injuries, and disabilities and rehabilitation. The primary aim of the work in this category will be to address the underlying determinants of NCDs, including socioeconomic, environmental, and occupational factors across the life course, as well as to strengthen the primary care response to NCDs, risk factors, and related conditions. The specific approaches are set out in the various PAHO/WHO mandates related to NCDs, including the Regional Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2019.

Context

2.1 Noncommunicable Diseases and Risk Factors

137. Over 75% of all deaths in the Americas are caused by NCDs, which are highly preventable and can be controlled through public policies and regulations, health services, and lifestyle interventions. Of particular concern is the burden of premature deaths from NCDs: in the Americas every year, over 1.5 million people under 70 years of age die from NCDs, which has serious implications for social and economic development. Because NCDs are largely a result of globalization, urbanization, demographic trends, and socioeconomic conditions, interventions are required not only from the health sector but from other government sectors such as agriculture, education, transport, labor, environment, and trade, as well as from civil society and the private sector. Cardiovascular diseases, diabetes, and cancer are all rising problems in the Region of the Americas, and with an aging and growing population, the situation is expected to worsen. Thus, policies and services to reduce the major risk factors and promote health in communities, workplaces, schools, and other settings are urgently needed. And to better control NCDs, health systems and services need to be strengthened, particularly at the

primary level of care, for screening, early detection, and management of NCDs and risk factors, ensuring access to medicines, technologies, and continuous quality of care.

138. Tobacco use is one of the most important NCD risk factors. The prevalence of adult smoking in the Region of the Americas is 22%, and 16% of the total mortality in adults is attributable to tobacco. The consumption gap between males and females is narrowing, especially among adolescents. Tobacco use also reflects social inequalities, with greater prevalence among lower-income and lower-education population groups. In the Region, 29 countries have ratified the WHO Framework Convention on Tobacco Control (FCTC). Although some 20 countries have passed legislation complying with at least one of the treaty mandates, much more progress is needed. Tobacco industry interference remains a major challenge in the Region, holding back progress in implementation of the WHO FCTC.

139. Alcohol consumption is another leading risk factor for NCDs, responsible for at least 347,000 deaths in 2004 in the Region and the loss of over 13 million disability-adjusted life years (DALYs). Average per capita consumption is estimated at 8.7 liters among those over 15 years of age, compared to the global average of 6.1 liters. The pattern of drinking measured through weekly episodic drinking (17.9% of men and 4.5% among females is of high risk). The expansion of the alcoholic beverage industry in the Region and its aggressive marketing and promotion in the absence of effective regulatory control remains a significant obstacle to the adoption of an effective response.

140. Obesity is linked to several NCDs, and in the Americas one in two adults and nearly 30% of school-age children and adolescents are overweight (BMI >25). The Region's rapid urbanization, rising salaries, and economic growth have caused an "epidemic" of unhealthy diets and sedentary lifestyles that in turn have produced the obesity problem. This includes the globalization of marketing of processed foods and sugary drinks, the tremendous popularity of electronic entertainment and computers, the centrality of the private automobile in urban planning and design, and the growing fear of street crime that prevents people from using the streets as a venue for interaction and entertainment. With the adoption of the WHO Global Strategy on Diet, Physical Activity and Health (DPAS), the emphasis is now on the critical importance of the food environment that influences preferences, purchasing decisions, and eating behavior.

2.2 Mental Health

141. Mental, neurological, and substance abuse disorders represent an important cause of morbidity, mortality, and disability. Eight priority conditions make the largest contribution to morbidity in the majority of developing countries: depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs, and mental disorders in children. In the Region, the conditions that require particular attention include depression, disorders

due to alcohol use, dementia, and mental health conditions of children and adolescents, including suicide prevention. These are major determinants and causes of morbidity. PAHO will focus on information and surveillance, broadening the evidence base on mental health; on development of policies, plans, and legal instruments, with a particular emphasis on protection of human rights; on development and integration of the mental health component of primary care; and on the provision of mental health care and psychosocial support in disasters and humanitarian emergencies. In this regard, the restructuring of mental health services should continue as a priority in Latin America and the Caribbean.

2.3 Violence and Injuries

142. Violence and injuries represent a major cause of morbidity and mortality in the Americas, with homicides being the first cause of mortality among men aged 15-29 and the second cause of among women in the same age group. Road traffic injuries are the leading cause of death in children aged 5-14 years and the second cause in the group aged 15-44 years in the Americas. For each person who dies as a result of violence and injuries, many more suffer a range of long-term physical and mental health consequences. Different forms of violence affect populations in distinct ways. While men, including young men, are likely to be attacked by a stranger or an acquaintance, women are more likely to suffer violence at the hands of their husband or intimate partner, and children are more likely to be abused by adults close to them.

143. Violence poses considerable direct and indirect costs to societies. Violence drains health, social, and justice sector budgets with expenditures for treating survivors and apprehending and prosecuting perpetrators. Violence also reduces productivity, increases absenteeism, and poses considerable intergenerational costs from the impacts of violence on survivors' children. Additionally, fear of violence can further exacerbate inequalities by isolating the poor in their homes and the rich in their segregated spaces, affecting the well-being and social fabric of families and communities.

2.4 Disabilities and Rehabilitation

144. In the Americas an estimated 140 million to 180 million people were living with some form of disability in 2010. This number is expected to increase due to population growth, aging, rise of NCDs, accidents, disasters, violence, poor diet, and substance abuse. Limited resources, poor policy, limited access to health services/rehabilitation, and transportation represent significant challenges for people with disabilities. Ocular, hearing, and oral health need to be addressed, given that about 80% of blindness in the Americas is avoidable and dental caries affect more than 90% of the Region's population (inclusion of ocular, hearing and oral health in the Plan pending budget confirmation).

145. PAHO will contribute to the improvement of the situation and conditions of people living with disabilities in the Region through technical cooperation and promotion of community participation, as well as through a rights-based approach. Access to health services, including rehabilitation services, will be strengthened for persons with disabilities. This will include generating synergies between related health programs for health promotion and prevention of disabilities, strengthening capacity of health human resources, providing social protection for people with disabilities, and improving information on disabilities within health information systems.

2.5 Nutrition

146. Poor nutrition results in stunted child growth and in overweight and obesity throughout the life course. This in turn is an important risk factor for three of the four major NCDs; cardiovascular disease, cancers, and diabetes. Preventing both undernutrition and overweight/obesity is central to the achievement of global development goals and to decrease their burden for individuals, communities and the health system, and their role in impeding human and economic development and equity. Regional targets have been set for exclusive breastfeeding and for reduction of child stunting, overweight, and women's anemia.

147. PAHO will support strengthening of the evidence base for effective interventions, assist in the development and evaluation of policies and programs, and provide the leadership, practical knowledge, and capacities required to scale up actions. The Organization will provide technical cooperation for improving environments—for example, to support breastfeeding in hospitals or healthy meals and recreation in schools—and engage the private sector in the areas of staple food fortification and product reformulation. It will also provide frameworks for regulations in the areas of food labeling and marketing of foods and beverages to children, among others. All these actions will make use of multisectoral approaches involving key actors such as ministries of education, agriculture, and the environment. Lastly, PAHO will monitor progress toward achievement of agreed nutrition targets by Member States.

Key Stakeholders' Analysis

148. The main stakeholders for this category include the ministers of health and national health authorities responsible for NCDs and risk factors, nutrition, mental health, violence and injuries, disabilities, and rehabilitation, including ocular, oral, and hearing programs. Because a whole-of-government approach is required to address NCDs and their risk factors, key stakeholders also include those from sectors outside of health, such as agriculture, education, transport, labor, environment, and trade. PAHO also partners on these program areas with stakeholders outside of government, including civil society

actors (nongovernmental organizations, international organizations, professional associations, and academia) as well as the private sector.

149. PAHO has strong partnerships with WHO Collaborating Centers related to the category, and also with numerous professional associations, academics, nongovernmental organizations, and private sector organizations working in the area of NCDs. This collaboration takes place principally through the Pan American Forum for Action on NCDs (PAFNCD), but these linkages are also well established in other initiatives linked to the specific program areas within the category. The Healthy Caribbean Coalition, the Latin America Coalition for Health, and the Framework Convention Alliance are key civil society coalitions with which PAHO collaborates, particularly for social mobilization and communications around NCD and risk factor prevention and control.

150. PAHO is also collaborating with United Nations agencies, including the International Telecommunications Union, UNICEF, UNDP, United Nations Population Fund (UNFPA), and United Nations Office on Drugs and Crime, to scale up joint programming for NCDs and risk factors at regional and national levels.

151. Through its strong links to governments, PAHO has supported the various political declarations on NCDs. These include the Declaration of the High-level Meeting of the UN General Assembly on Prevention and Control of Noncommunicable Diseases; the Port-of-Spain Declaration on NCDs; the Andean ministers of health resolution on NCDs and NCD surveillance (REMSAA XXXIV/5 and REMSAA XXXII, 2011); the UNASUR resolution on NCDs; and the Central America and Dominican Republic Ministers of Health Declaration of Antigua, Guatemala, on NCDs, endorsed by the presidents of the Central American Integration System.

152. PAHO will continue to build and expand capacities within ministries of health to improve the multi-stakeholder response, effectiveness, and impact of national policies, programs, and services that relate to NCDs and their risk factors.

Strategies for Technical Cooperation

153. Priority will be placed on putting into action the various mandates and resolutions on NCDs, risk factors, and related conditions, particularly the WHO Framework Convention on Tobacco Control (a legally binding global treaty) and the Regional Plan of Action on Non-Communicable Diseases in keeping with efforts toward the achievement of global targets and indicators set forth in the NCD Global Monitoring Framework. PAHO will lead, together with Member States, a multisector response, articulating policy and regulatory options to address the broader physical, social, and economic environmental conditions that support healthy nutrition, risk factor reduction, mental health, violence prevention, disability and rehabilitation, and management of NCDs. This

will involve developing effective partnerships and exercising a leadership and coordination role with the relevant United Nations funds, programs, and agencies. PAHO's work will draw heavily on its normative and capacity-building competencies.

154. PAHO will support Member States in their efforts to establish national plans and strengthen policies, programs, and services, emphasizing the primary health care approach to NCDs, risk factors, and related conditions. The focus will be on prevention throughout the life course and on screening and early detection of cancer, diabetes, and cardiovascular diseases and their risk factors. Additional priorities will include improving the quality of care, increasing access to affordable diagnosis and treatment, reducing the suffering of people living with disabilities and chronic diseases, and supporting strategies and technologies suitable for primary health care settings and workplaces in resource-constrained settings. PAHO will also support information, surveillance, and research, broadening the evidence base to support national policies, strategies, and laws, with a focus on protection of rights. Work in the area of mental health will include provision of mental and psychosocial support in humanitarian emergencies.

Cross-Cutting Themes and Strategic Approaches in Health

155. Category 2 and its program areas will require inter-programmatic work with all other categories, especially Category 1 (Communicable Diseases), Category 3 (Determinants of Health and Promoting Health throughout the Life Course), and Category 4 (Health Systems). Linkages with Category 1 include co-morbidities (for example, tuberculosis and diabetes, HIV/AIDS and mental health) and vaccines to prevent some types of cancers (HBV vaccine for liver cancer, HPV vaccine for cervical cancer). With respect to Category 3, there are strong linkages between neonatal and early childhood mortality and morbidity and promotion of healthy nutrition (particularly breastfeeding) as a means to prevent NCDs. The strategies to prevent and control NCDs also support active and healthy aging. The multisectoral actions required for NCD prevention are those that address the social determinants of health as well as environmental threats to health and gender equity. The linkages with Category 4 are particularly strong, since a primary care approach, people-centered care, and access to medical technologies are all essential for NCD management. The nature of the issues covered under Category 2 require strong multisectoral collaboration in order to address the underlying causes of NCDs and associated risk factors in a more effective manner.

156. Addressing the social determinants of health plays a critical role in the strategy to respond to the burden of NCDs, risk factors, and related conditions. Health promotion strategies are also an essential component of NCD prevention, especially childhood and adolescent health promotion to inculcate, in the early stages of life, healthy ways of living. Primary health care is another essential component of the management of NCDs and risk factors, mental health, disabilities and rehabilitation, and violence/injury

prevention. PAHO will integrate NCD and risk factor management interventions as part of overall efforts to strengthen health systems based on the primary care approach. Equitable care for NCDs, risk factors, and related conditions requires social protection in health; therefore, prevention and control of NCDs and risk factors should be included in social protection packages.

157. PAHO's cross-cutting themes of gender, human rights, equity, and cultural diversity will be taken into consideration in achieving all of the outcomes and outcome indicators noted below.

Category 2. Noncommunicable Diseases and Risk Factors

Program Areas and Outcomes

(BASELINES AND TARGETS UNDER REVIEW PENDING CONSULTATION WITH COUNTRIES) [See#1 note in category]

2.1 Noncommunicable Diseases and Risk Factors

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 2.1 Increased access to interventions to prevent and manage noncommunicable diseases and their risks factors	OCM 2.1.1	Total (recorded and unrecorded) alcohol per capita consumption (15+ years of age)	8.67 liters (2003-2005)	7.8 liters (10% reduction)
	OCM 2.1.2	Prevalence of current tobacco use (15+ years of age)	21% (2010)	17%
	OCM 2.1.3	Prevalence of insufficient physical activity in youth 13-15 years of age	60%	55%
	OCM 2.1.4	Percentage of persons with controlled hypertension (<140/90 mmHg)	15%	35%
	OCM 2.1.5	Percentage of persons with controlled diabetes	15%	35%
	OCM 2.1.6	Number of countries with a stable prevalence of obesity	0	2 COR, PER
	OCM 2.1.7	Mean population intake of salt/sodium	11.5 grams (2010)	5 grams
	OCM 2.1.8	Number of countries with cervical cancer screening coverage of 70% by 2019	5 BRA, CAN, CHI, JAM, USA	15 ARG, BOL, COL, COR, GUA, GUY, HON, PAR, MEX, TRT
	OCM 2.1.9	Number of countries with a point of prevalence rate of reported treated end-stage renal diseases of at least 700 patients per 1 million population	7 ARG, BRA, CAN, CHI, MEX, URU, USA	14 ELS, COL, COR, CUB, DOM, ECU, VEN

2.2 Mental Health and Substance Use Disorders

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 2.2 Increased capacity to access service coverage for mental health and substance use disorders	OCM 2.2.1	Number of countries that have increased the rate of users treated through mental health outpatient facilities above the regional rate of 975/100,000 population	20 ARG, BLZ, BOL, BRA, BVI, CAN, CHI, COR, CUB, DOM, JAM, HAI, PAN, PER, SCN, SUR, TRT, URU, USA	30 (list of countries to be confirmed during national consultations)

2.3 Violence and Injuries

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 2.3 Reduced risk factors associated with violence and injuries with a focus on road safety, child injuries, and violence against children, women, and youth	OCM 2.3.1	Number of countries with at least 70% use of seat belts in rear seats	2 CAN, USA (2013 WHO report)	7 COL, COR, ECU, PAR, SCN
	OCM 2.3.2	Number of countries that use a public health perspective in an integrated approach to violence prevention	1 BRA	6 ELS, MEX, NIC, PER, TRT

2.4 Disabilities and Rehabilitation

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 2.4 Increased access to social and health services for people with disabilities, including prevention	OCM 2.4.1	Number of countries reaching 12% access to social and health services for people with disabilities, developed as part of the global plan of action on disability	0	14 ARG, BRA, BOL, CHI, COL, COR, CUB, ECU, ELS, GUT, MEX, PER, URU, VEN
	OCM 2.4.2	Number of countries and territories reaching cataract surgical rate of 2,000/million population/year	14 ARG, BAH, BAR, BRA, CAN, CHI, COR,CUB, DOM, SAL, TRT, USA, URU, VEN	20 COL, ELS, MEX NIC, PAN, PER
	OCM* 2.4.3	Number of countries and territories reaching DMFT index < 2 at age 12.	23 ANU, ANI, BAH, BAR, BLZ, BER, CAN, CAY, CHI, CUB, CUR, DOM, ECU, ELS, GUY, HAI, JAM, MEX, MON, USA, SUR, TCA,TRT	32 BOL, DOR, GUT HON, PAN, PER

* Inclusion subject to budget confirmation

2.5 Nutrition

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 2.5 Nutritional risk factors reduced	OCM 2.5.1	Percentage of children less than 5 years of age who are stunted	13.5% (2010)	7.5%
	2.5.2	Percentage of women of reproductive age (15-49 years) with anemia	22.5% (2010)	18%
	2.5.3	Percentage of children less than 5 years of age who are overweight	6.9% (2009)	7%

Category 3 - Determinants of Health and Promoting Health throughout the Life Course

Promoting good health at key stages of life, taking into account the need to address the social determinants of health (societal conditions in which people are born, grow, live, work, and age), and implementing approaches based on gender equality, ethnicity, equity, and human rights.

Scope

158. This category brings together strategies for promoting health and well-being from preconception to old age. It is concerned with *(a)* health as an outcome of all policies; *(b)* health in relation to development, including the environment; and *(c)* the social determinants of health, which embrace gender, equity, human rights, and ethnicity mainstreaming and capacity building.

159. The category is by its nature cross-cutting and is critical for addressing the social determinants of health and equity in order to improve health outcomes in the Region. It addresses population health needs with a special focus on key stages in life. This approach enables the development of integrated strategies that are responsive to evolving needs, to changing demographics, to epidemiological, social, cultural, environmental, and behavioral factors, and to widening health inequities and equity gaps. The life-course approach considers how multiple determinants interact and affect health throughout life and across generations. Health is considered as a dynamic continuum rather than as a series of isolated health states. The approach highlights the importance of transitions, linking each stage to the next. It defines protective and risk factors and prioritizes investment in health care and social determinants, gender, human rights promotion and protection, and ethnic/racial approaches in health. Moreover, the work undertaken in this category contributes to the achievement internationally agreed goals such as the Millennium Development Goals (MDGs), especially MDG3 (gender equality and women's empowerment), MDG 4 (reduce child mortality), and MDG 5 (improve maternal health). It is also consistent with universal and regional human rights treaties and standards and responds to the vision of the post-2015 development agenda.

Context

160. In the Region of the Americas, life expectancy at birth has increased from 69.2 in 1980 to 76.1 in 2011. Yet, despite much progress, stark inequities persist in the Region, and glowing indicators often mask significant differences between and within countries. The Region has experienced a demographic transition and rapid urbanization. It has a high degree of ethnic diversity, and racial/ethnic minority populations face higher rates of

poverty, health inequities, and limited access to health services. Indigenous populations, Afro-descendants, and Roma, among others, require specific measures to offset health inequities.

161. The approach based on social determinants of health looks at the whole picture in each country, addressing the interrelated factors that affect overall health and well-being. It allows public health professionals to look outside the health care systems for solutions to health inequities. Moreover, it provides a framework to improve the health of people while encouraging equitable opportunities across the life course, promoting civil society participation and community empowerment.

162. Gender interacts with other determinants of health to influence overall health status. Populations facing inequalities based on gender, ethnicity, age, place of residence, religion, language, sexual orientation, or other factors tend to have higher vulnerabilities and worse health outcomes.

163. Health and human rights law, as enshrined in universal and regional human rights conventions and standards, offers a unifying conceptual and legal framework in which to focus strategies on vulnerable groups as well as a mechanism by which to evaluate success and clarify the accountability and responsibilities of the different stakeholders.

164. Although many countries have made significant progress in reducing maternal mortality, national averages conceal inequities. Each day in the Region, about 30 women die from causes related to pregnancy or childbirth. Improved data collection and information systems are needed to better monitor maternal health. Groups in vulnerable conditions (rural populations, indigenous groups, adolescents) require targeted actions based on gender, equity, human rights, and social determinants of health approaches. Improvements in maternal mortality reduction should include strategies to collect better information and address severe maternal morbidity ("near miss"). HIV/AIDS feminization, mental health, domestic, intimate partner, and sexual violence, menopause, and gynecological cancers remain as challenges in the Region. A fundamental and still emerging issue in women's health care policies is the interface with noncommunicable diseases such as obesity, hypertension, and diabetes, now major causes of the disease burden for women.

165. Comprehensive and integrated approaches to sexual and reproductive health are needed in the Region. This involves a comprehensive assessment of the needs and demands of women throughout the life course, including the preconception, prenatal, childbirth, postpartum, and menopause periods. As part of comprehensive programs for sexual and reproductive health, consideration should be given to the inclusion of contraception and abortion in development and implementation of health care

interventions. In relation to services for men, comprehensive sexual and reproductive services, including for prostate cancer, remain a challenge in the Region.

166. The children of the Region of the Americas are its greatest asset, and the recognition and protection of their distinct needs and human rights is essential for effective development. The Region has made great strides in reducing child mortality and morbidity, and Member States have achieved better levels of integration of child health services in health facilities. However, to make such integration even more effective, national health policies, strategies, and plans, as well as legislation and regulations, must use an intersectoral, inter-programmatic, and life course approach. Conditions at birth and in the early stages of life strongly influence health and development throughout the life course. Although there have been significant reductions in child mortality, there are persistent challenges in the Region that need to be addressed. Neonatal mortality is the main component of infant mortality and under-5 mortality, and the leading causes of death are preventable. Each year, 210,000 children die before their fifth birthday, more than 60% of them during the first month of life. Various adverse conditions in the early stages of life are associated with negative impacts on growth, development, and sensory capabilities, which in turn affect the individual's quality of life and ability to work and learn; this, ultimately, affects the country's human capital. There is also evidence concerning the contribution of certain childhood conditions to the development of chronic diseases in adulthood.

167. Persistent social exclusion and inequalities have detrimental effects on children's development and constitute one of the greatest challenges in the Region. Children who lag behind developmentally in their first five years may never catch up to those who had a better start in life. Eighty percent of the brain's capacity develops before 3 years of age; however, early childhood development programs have low coverage, and many child survival strategies still use a vertical approach that fails to consider the environmental conditions and other social determinants of health. Countries face challenges in scaling up health service delivery strategies, both clinical and community-based, to achieve health goals, and in estimating the resource requirements and financial implications of these strategies, especially for excluded populations.

168. The adolescent and youth population currently accounts for 26% of the total population, the largest that this cohort has been compared to other age groups in the history of the Region. The adolescent fertility rate (73.4 per 1,000 adolescent females 15-19 years of age) remains high compared to the global level (52.7 per 1,000). Twenty-one percent of adolescents are considered overweight, and 6% are obese; at the same time, anemia continues to be a significant problem among young women. In addition, violence and substance use among youth are a worrisome problems in the Region. The disproportionate impact of these issues on low-income, cross-border, and ethnic minority young people is of special concern and will be a focus of research and intervention.

169. Healthy, independent older persons contribute to the welfare of their households and communities. In the next 10 years, the Region will have double the number of older persons (over age 65) as in the year 2000. Although adults who reach age 60 have an increased life expectancy of about 21 years, 10 of these years are typically spent in poor health. Older adults face social and economic inequities along with multiple chronic conditions and disabilities that are complicated by lack of social and health protection and poor access to quality services. The availability of household resources to support the elderly has rapidly declined, and therefore more older adults will not have this type of care available. Timely and adequate interventions will make it possible to address these challenges and increase the contributions of older persons to social and economic development.

170. Sustainable development is redefined from the interdependency and synergy among social, economic, and environmental policies, to health and well-being of the population. Environmental factors influence the health of individuals and of populations. On average, environmental determinants of health are responsible for an estimated 25% of the global burden of disease. They are responsible for an estimated 1 million deaths in the Americas annually. The principal environmental determinants of health in the Region include indoor air pollution from burning of solid fuels; ambient particulate matter and ozone pollution; residential radon; household hazardous exposure to metals, especially lead, mercury, and methyl mercury; pesticides; hazardous wastes; lack of sustainable access to safe drinking water and basic sanitation; as well as major occupational risk factors. Environmental determinants of health are characterized by strongly inequitable distribution, interacting with other inequalities in health. The environmental burden of disease and its unfair distribution in the Region represents a major threat to health equity, universal health coverage, economic security and growth, sustainable human development, regional governance, and the attainment of global development goals.

3.1 Women, Maternal, Newborn, Child, and Adolescent Health, and Sexual and Reproductive Health

171. Effective interventions exist for improving the health of women and children and reducing maternal, neonatal, and child mortality. The challenges are to implement and expand those interventions, making them accessible to all during preconception, pregnancy, childbirth, and the early years of life, and ensuring quality of care. Half of maternal deaths, one-third of neonatal deaths, and one-third of stillbirths, as well as most of the complications that can lead to death of the mother or the newborn infant, occur in the 24 hours around delivery. It is also within this period that the most effective interventions to save the lives of mothers and babies can be delivered: management of labor, administration of oxytocin after delivery, resuscitation of the neonate, early initiation of breastfeeding, and interventions for children with birth defects. Work in this

area receives high-level commitment through its inclusion in MDGs 4 and 5; it is also a focus of the Commission on Information and Accountability for Women's and Children's Health.

172. Family planning can prevent up to one-third of maternal deaths, but in 2012 more than 200 million women had unmet needs for contraception. The implementation of sexual and reproductive health (SRH) policies, as part of reproductive health rights, needs to be consolidated and strengthened in the Region. Significant challenges include ensuring family planning supplies; universalization of emergency contraception; ensuring availability of male and female sterilization services; expanding health services capacity to address infertility; ensuring abortion care in cases permitted by law, particularly in pregnancies resulting from sexual violence; and integrating SRH programs with hypertension, diabetes, and mental health services, given the high burden of these diseases.

173. During the period 2014-2019, the Secretariat will continue to work on promoting effective interventions to decrease under-5 mortality rates in developing countries to levels approaching those in wealthier countries, and to reduce disparities between the poorest and wealthiest children within nations, with particular attention to treatment of pneumonia and diarrhea and effective coordination with related vaccine-preventable diseases and environmental programs.

174. For adolescents, the work will focus on investment in protective factors at the individual, family, and community levels to promote and protect healthy behaviors and prevent risk factors. Priority will be given to poor adolescents in vulnerable situations and to the areas of sexual and reproductive health, intimate partner and sexual violence, mental health, nutrition, accidents, substance use and abuse, and noncommunicable diseases, within a human rights framework.

3.2 Aging and Health

175. Promoting health with the life course approach will produce more active and healthy aging. In the period 2014-2019, the Secretariat will prioritize the health of the 150 million older persons currently living in the Region and the additional 50 million who will enter old age before 2025. These efforts will focus on maintaining their functional ability to live actively and independently in their communities, reducing disability rates and demand for long-term care and health systems and social assistance; promoting the health of older persons in public policy; adapting health systems to meet the challenges associated with aging; supporting human resources development to meet this challenge; and generating the information necessary to implement and evaluate interventions.

3.3 Gender, Equity, Human Rights, and Ethnicity Mainstreaming

176. Gender equality in health is a progressive goal to ensure that women and men, in a context of sexual and ethnic diversity, have equal opportunities to access the resources necessary to protect and promote their health. Preconditions to achieve gender equality include the State's fulfillment of its obligations related to the Right to Health and addressing gender inequities.

177. A synergistic approach will be used in the institutional mainstreaming of gender, equity, human rights, and ethnicity at all levels of the Organization. This involves designing and establishing structural mechanisms that enable programmatic mainstreaming (policies, plans, and laws) to succeed, and that support countries in the achievement of gender, equity, and ethnic equality and the realization of the right to health and related human rights. The crucial challenges for achieving the above within PAHO and the countries include developing sufficient expertise regarding human rights law instruments and accountability mechanisms applicable to the life course, social determinants, gender, equity, cultural diversity, and their integration within health systems.

3.4 Social Determinants of Health

178. Work on the social determinants of health affects all PAHO areas of operation. During 2014-2019 PAHO will continue to focus on the social determinants of health and their links with health promotion, addressing equity across all five programmatic categories (excluding Category 6, Corporate Services/Enabling Functions) of the Strategic Plan. In addition, capacity building on mainstreaming the social determinants of health approach will continue in the Secretariat and in Member States. Tools and guidelines are needed to implement Health in All Policies with the objective of building greater awareness of the value added through the social determinants of health approach and its link to health promotion that encourages increased community participation and empowerment for health. The Secretariat will also develop a standard set of indicators to monitor action on social determinants of health and to implement and monitor the joint work plan on social determinants of health with partners within and outside the health sector. This will require collecting disaggregated data to improve the analysis and understanding of inequities and social gradients in health in the Region, as well as within countries.

179. Health in All Policies draws from national and international developments in the area of health policy and comprehensive health care, including the Alma Ata Declaration, the Ottawa Charter, the Universal Declaration of Human Rights, and the Rio Political Declaration on Social Determinants of Health. The Rio Political Declaration, adopted in 2011 during the World Conference on Social Determinants of Health, expresses

worldwide political commitment to implement an approach geared toward the social determinants of health. This allows countries in the Region to build momentum for developing their own national action plans and multisectoral strategies dedicated to reducing inequities.

180. Finally, as articulated in the Rio Political Declaration, PAHO will focus on the need for better governance, including coordination and guidance, of the growing number of actors in the health sector, an area generally referred to as health governance. The social determinants approach to health promotes governance through partnerships and networks with different sectors of society, aimed at addressing the stark inequities in the Region through concrete actions and consensus-based public policies. The goal is to attain the highest possible level of health for all and the implementation of universal and regional human rights law treaties and standards applicable to health.

3.5 Health and the Environment

181. Action on the environmental and social determinants of health is imperative to build inclusive societies in healthy, safe, and sustainable environments, in which people can fulfill their potential and lead long, healthy, dignified, and productive lives. This requires specific action to address environmental inequalities in health. Consistent with the large body of global and regional commitments, agreements, and mandates on issues pertaining to environmental health, PAHO's technical cooperation in this priority area will focus on: *(a)* strengthening the national health authorities' stewardship of environmental health; *(b)* increasing institutional capacities in environmental health, including professional competencies in the assessment of environmental health risks and impacts, in monitoring environmental inequalities in health, and in the generation of an evidence base to inform policy; *(c)* advancing environmental health promotion and care, with emphasis on the implementation of primary environmental services as a policy direction for local action; *(d)* promoting actions to reduce environmental inequalities and their impact on health through actions that cross environmental and social gradients as well as those that target vulnerable populations; and *(e)* strengthening specific programs on current and emerging environmental threats with local health impacts, such as climate change, loss of biodiversity, ecosystem depletion, water scarcity, and desertification.

Key Stakeholders' Analysis

182. The work will be undertaken in the context of the UN Secretary-General's Global Strategy for Women's and Children's Health, within the framework of the Every Women Every Child Initiative, with partners such as H4+ (WHO, UNICEF, UNFPA, the World Bank, UNAIDS, UN Women), and the Partnership for Maternal, Newborn and Child Health, with other United Nations partners such as UNDP and United Nations Population Division. Collaboration with the Organization of American States (OAS), academic and

research institutions, civil society and development partners, with the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, as well as with the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance, will also be key in this area in order to ensure complementarity and accelerate action in the final push toward achieving MDGs 3, 4, and 5.

183. One of the overarching goals of the post-2015 development agenda is maximizing health at all stages of life. Work in this category is essential for this goal, as is achieving the goal of universal health coverage. Critical to these are the approaches of social determinants of health and health promotion throughout the life course.

184. With the experience it has gained through the work of the UN Platform on Social Determinants of Health in 2012-2013 (International Labour Organization, UNAIDS, UNDP, UNFPA, UNICEF, and WHO), the Organization is well placed to advocate for action on social determinants of health, including their integration into the post-2015 development agenda, as well as to provide technical support to Member States in this area. A network of institutions will be established to strengthen capacities of Member States to implement the five action areas enshrined in the Rio Political Declaration on Social Determinants of Health.

185. PAHO will maintain its role within UN-Water, strengthen its collaboration with UNICEF on global monitoring of water and sanitation, and lead an initiative for ensuring water quality through a new collaborative framework with UN-HABITAT on urban environmental health issues. The Organization will continue to host the secretariat for, and participate in, the Inter-Organization Programme for the Sound Management of Chemicals. PAHO will further strengthen the representation of health within the overall United Nations response to climate change through the High-Level Committee on Programmes of the United Nations System Chief Executives Board for Coordination. The Organization will provide technical health input to programs under the United Nations Framework Convention on Climate Change, and to specific partnerships with other organizations in the United Nations system.

Strategies for Technical Cooperation

(a) Ensure the availability of data for measurement of trends related to social determinants of health, human rights, and ethnicity and gender equality as they relate to health in the Region.

(b) Strengthen surveillance, monitoring, and evaluation systems to expand the research and evidence base for policy planning and evaluation through adequate investment, capacity strengthening, and effective partnership between the academic and public sectors.

(c) Advocate with governments to prioritize a healthy life course using a framework of social determinants, human rights, cultural diversity, and gender equality in health, through education, policies, and a communication plan, emphasizing intersectoral action and public-private partnerships.

(d) Strengthen national strategies and plans to address health in all public policies, involving civil society and relevant stakeholders through community-based initiatives.

(e) Support the incorporation of gender equality, ethnic/racial equality, poverty reduction, and human rights perspectives into preparation of health guidelines, policy making, and program implementation to address the root causes of health inequities, discrimination, and inequality with regard to the most vulnerable groups.

(f) Implement existing regional plans and strategies agreed with Member States, including PAHO Governing Bodies resolutions, that relate to health throughout the life course, social determinants, human rights, cultural diversity, gender equality in health, and the environment, and that integrate interventions on the main health issues using promotion and prevention strategies.

(g) Contribute to health systems strengthening by:

- Integrating and harmonizing programs and interventions along a continuum of care that runs throughout the life course and spans the home, the community, and different levels of the health system and services.
- Expanding, integrating, and reorienting services for the delivery of gender-sensitive, cost-effective interventions throughout the life course using social determinants, human rights, and gender equality in health frameworks, through prevention, diagnosis, treatment, care, and support, ensuring services for hard-to-reach populations and vulnerable groups, including indigenous populations.
- Building capacity of the public health workforce to provide public health interventions and high-quality health care in response to new demands linked to demographic and epidemiological trends.
- Promoting community-based interventions and supporting appropriate care in the home throughout the life course.

(h) Establish and maintain effective coordination with other partners across all relevant sectors at the country, subregional, and regional levels and promote partnerships with bilateral and UN agencies to harmonize actions that scale up interventions and maximize the use of resources, strengthening the network of WHO Collaborating Centers located in the Americas.

(i) Foster transfer of technology and new modalities of technical cooperation (e.g., South-to-South), leveraging and mobilizing technical expertise across the Region and fostering the exchange of lessons learned among Member States.

(j) Strengthen the strategic alliance between the health and environment ministries to build stronger links between the health and environmental sectors in planning and implementation of national policies.

(k) Mobilize resources for all the strategic approaches to improve health throughout the life course.

(l) Ensure that technical cooperation is tailored to the needs of the Member States and their populations, focusing technical cooperation on the key countries as defined in this Strategic Plan and on the priority countries identified for this category.

Cross-Cutting Themes and Strategic Approaches in Health

186. This category has many linkages with other PAHO areas of work. There are special working relationships with communicable diseases and vaccines, nutrition, food safety, and integrated, people-centered health services that provide primary health care for reducing maternal and child mortality and morbidity along the life course. There are also links between programs dealing with risk behaviors in adolescence and with NCDs in adults. The Secretariat's response to the health needs of older populations is multifaceted and involves all parts of the Organization. Particularly important will be close collaboration with health analysis and NCDs and mental health along the life course, and older people's access to health care and long-term care and prevention of disabilities. Equally important is the link with efforts to ensure the health of women, children, and the elderly during emergency situations.

187. Additionally, by its very nature, work in this category—namely, efforts in support of health across the life course and cross-cutting themes such as mainstreaming of gender, equity, ethnicity, and human rights—contributes to, and benefits from, work in all other categories. The category will serve as the hub to ensure that technical work in these cross-cutting areas is mainstreamed across all program areas. In addition, intersectoral collaboration for addressing the social and environmental determinants of health will need to be promoted.

Category 3. Determinants of Health and Promoting Health throughout the Life Course

Program Areas and Outcomes

(BASELINES AND TARGETS UNDER REVIEW PENDING CONSULTATION WITH COUNTRIES) [see comment in #1]

3.1 Women, Maternal, Newborn, Child, and Adolescent Health, and Sexual and Reproductive Health

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 3.1 Increased access to interventions to improve the health of women, newborns, children, and adolescents	OCM 3.1.1	Percentage of unmet need for modern family planning methods	44%	25%
	OCM 3.1.2	Percentage of live births attended by skilled health personnel	95%	99%
	OCM 3.1.3	Percentage of mothers and newborns receiving postnatal care within seven days of childbirth	40%	65%
	OCM 3.1.4	Percentage of infants aged 0-5 months who are exclusively breastfed	43.8%	54.0%
	OCM 3.1.5	Percentage of children aged 0-59 months with suspected pneumonia receiving antibiotics (under review)	TBD	TBD
	OCM 3.1.6	Specific fertility rate in women 15-19 years of age and <15 years	60	52

3.2 Aging and Health

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 3.2 Increased access to interventions for older adults to maintain an independent life	OCM 3.2.1	Number of countries with increased access to integrated community service and self-care programs for older adults (under review)	5 CAN, CHI, COR,CUB, USA	18 Countries to be included during national consultations

3.3 Gender Equity, Equity in Health, Human Rights, and Ethnicity Mainstreaming

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 3.3 Increased country capacity to integrate gender, equity, human rights, and ethnicity in health	OCM 3.3.1	Number of countries with an institutional response to inequities in health (gender, health equity, human rights, and ethnicity)	24 ANU, ARG, BAR, BLZ, BOL, BVI, CAN, CHI, COL, COR, DOR, ECU,ELS, GUT, GUY, HON, MON, NIC, PAN, PAR, PER, SUR TRT, USA	29 CUB, BRA, HAI, SAL, URU

3.4 Social Determinants of Health

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 3.4 Increased leadership of the health sector to address the social determinants of health	OCM 3.4.1	Number of countries implementing at least two of the five pillars of the Rio Political Declaration on Social Determinants of Health	6 ARG, BRA, CAN, COL, COR, CHI	20 BAR, BLZ, BOL, CUB, ECU, ELS, PAN, PER, DOR, GUT, MEX, NIC, SUR
	OCM 3.4.2	Number of countries and territories with reoriented health sector to address health inequities	6 ARG, BRA, CAN, CHI, COR, MEX	13 BLZ, BOL, CUB, ELS, NIC, PAN, PER

3.5 Health and the Environment

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 3.5 Reduce environmental and occupational threats to health	OCM 3.5.1	Number of countries and territories reducing the gap between urban and rural populations' access to quality-controlled water according to WHO guidelines	6 ARU,BAR, CAN, SAV, TCA, URU	16 BOL, COR, GUY, GUT, JAM, HAI, HON, NIC, PER, TRT
	OCM 3.5.2	Number of countries in which the proportion of population relying on solid fuels is reduced	14 ARG, BAH, BAR, CAN, DOM, ECU, GRA, SAL, SAV, TRT, URU, USA, VEN	19 COL, GUT, HAI, NIC, PER

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
	OCM 3.5.3	Number of countries and territories with capacity to address environmental and occupational health	7 ARG, BRA, CAN, COL, MEX, PER, USA	12 Countries to be included during national consultations

Category 4 - Health Systems

Health systems based on primary health care, supporting universal health coverage

Strengthening health systems with a focus on governance for social protection in health; strengthening legislative and regulatory frameworks and increasing financial protection for progressive realization of the right to health; organizing people-centered, integrated service delivery; promoting access to and rational use of quality, safe, and effective health technologies; strengthening information systems and national health research systems; promoting research for integrating scientific knowledge into health care, health policies, and technical cooperation; facilitating transfer of knowledge and technologies; and developing human resources for health.

Scope

188. Universal health coverage (UHC) is one of the most powerful ideas in public health. It combines two fundamental components: *(a)* access to the quality services needed to achieve good health for every individual and community, including promotion, prevention, treatment, rehabilitation, and palliative/long-term care, along with actions to address the determinants of health; and *(b)* financial mechanisms, policies, and regulations required to guarantee financial protection and prevent ill health from leading to or worsening poverty. Advancing universal health coverage means promoting universal access to well-trained and motivated health care workers and to safe and effective health technologies, including medicines and other medical products, though well-organized delivery networks. It means building and maintaining strong health systems based on primary health care and grounded in a sound legal, institutional, and organizational foundation. Work in these areas must be guided by innovation, scientific evidence, and relevant knowledge. PAHO Member States are diverse in size, resources, and levels of development; UHC provides a powerful unifying concept to guide health and development and to advance health equity in the coming years. PAHO's leadership, both technical and political, will be crucial in championing UHC and enabling countries to achieve it.

Context

4.1 Health governance and financing; national health policies, strategies, and plans

189. Health systems in the Region face two main organizational challenges: segmentation due to different funding and affiliation schemes, and fragmentation due to provision of care by many different institutions and facilities that often are not integrated into networks. Other problems include lack of clear national health priorities and goals;

absence of comparable data; weak service management and regulatory capacities; and deficiencies in the availability, distribution, and quality of the health workforce. These problems contribute to inequities in health, inefficiency in health care services, and gaps in effective access to high-quality health services, including medical products and other health technologies.

190. While the 2012 Mid-term Evaluation of the Health Agenda for the Americas documents important progress in strategic health planning in a great majority of the countries in the Region, the strengthening of this function in the health sector is critical for effective leadership and governance. A key challenge related to leadership and governance of the health sector is insufficient access to and use of scientific knowledge to better understand the effects of public health programs and services.

191. Access to health services is only one of a number of determinants of health. The most affected populations are those that are the most vulnerable, historically excluded, and poor, such as indigenous and Afro-descendant people. There is a strong relationship between UHC and the social, environmental, and economic pillars of sustainable development. Consequently, millions of people in the Region do not have a guaranteed right to health, and resources are not used effectively to implement proven interventions to address health priorities and improve health outcomes. Policies and legal frameworks promoting equity in access to health care and health technologies are being addressed throughout the Region, along with social protection mechanisms to reduce or eliminate financial barriers.

192. UHC is conceived not as a minimum set of services but as an active process of progressive realization. It requires advancing in three dimensions: *(a)* the range of good-quality services that are effectively available to people; *(b)* the proportion of the costs of those services that are covered; and *(c)* the proportion of the population that is covered by the health services. Results of the Mid-term Evaluation of the Health Agenda for the Americas show progress in the steering role of national health authorities and suggest continued efforts strengthen all three dimensions. The development of good governance in health, as a process to build a common vision and align efforts, is essential for UHC. The proposed political strategy, which links health to broader social and economic goals, implies the implementation of evidence-based social protection policies with specific financial mechanisms geared to UHC.

4.2 People-Centered, Integrated, Quality Health Services

193. In the Americas, health services fragmentation is a common constraint. From the people's perspective, fragmentation means limited access to services, loss of continuity of care, and failure of services to meet users' needs. Its main characteristics are limited coordination across the different levels and points of care, duplication of services and

infrastructure, unutilized and underutilized productive capacity, and the provision of health services at the least appropriate locations, particularly hospitals. Universal health coverage implies a people-centered model of care and the development of comprehensive care networks to meet the needs and demands of the entire population throughout the life course. Transforming the way that care is provided will ensure access to effective, comprehensive health services, including vertical health programs, across the whole health care continuum. People-centered, integrated service delivery focuses on the health needs and expectations of people and communities, rather than solely on diseases. Meanwhile, evidence-informed policies make use of the best scientific evidence and other forms of knowledge in a systematic manner and promote appropriate and efficient approaches to improving health care and policies for health. Both aspects play a crucial role in shaping health policy and health services.

4.3 Access to Medical Products and Strengthening of Regulatory Capacity

194. Health technologies, including medicines and other medical products, are indispensable in the provision of health services, from prevention to palliative care. Improving access to health technologies is an essential step toward achieving UHC, and an indispensable part of this is developing and implementing policies to strengthen governance and management of health technologies. Important disparities exist in access to medicines and other health technologies among countries in the Americas and among different socioeconomic groups within the same country. In most low- and middle-income countries, health technologies constitute the largest public expenditure in health after personnel costs, as well as the largest household health expenditure. The inappropriate and irrational use of medicines and other health technologies not only inflates health care costs but also diminishes the quality of care, jeopardizes patient safety, and compromises overall health outcomes. While some countries of the Region have strengthened their capacity for technological innovation in health, many innovation priorities are yet to be addressed. Newer health technologies are becoming available, but they often cost more than those they replace. Thus, health technology assessments (HTAs) should guide decision making regarding the acquisition of new technologies and their implementation within health services, and practice guidelines should be prepared to improve quality of care and optimize resources for health. Appropriate regulatory capacity is required to ensure the availability of safe, quality, and effective medicines and other health technologies, and strengthening such capacity has become a priority for countries of the Americas in their quest to advance toward UHC.

4.4 Health Systems Information and Evidence

195. Health information is a key input that supports all aspects of health action, including research, planning, operations, surveillance, monitoring, and evaluation, as well as prioritization and decision making. However, disparities persist between countries

regarding the coverage and reliability of health information systems and the timeliness and quality of the information they provide. Countries also differ in their research and analytical capacities to produce health data and use it to analyze the causes of problems and the best available options for addressing them. Communities need to play a more active role in the generation and dissemination of evidence to better guide actions aimed at improving the health status of the population.

196. Improving the living conditions of the population and reducing inequities in health outcomes requires actions to strengthen the capacity for health situation analysis, improve generation and sharing of evidence, and facilitate its translation into policies and its application to public health practice. Scientific evidence and health information must be integrated into decision-making processes at all levels of the health system in order to achieve evidence-based health care and evidence-informed policy making. PASB will continue to develop guidelines and tools, produce multilingual and multi-format information products, promote sustainable access to up-to-date scientific and technical knowledge by PASB staff and national health care professionals, and contribute to the empowerment of patients through reliable information. In addition, PASB will manage and support knowledge networks, translating evidence into policies and practices and promoting the appropriate use of information and communication technologies (ICT).

197. Health information is considered a basic right of people. The development and use of ICT, the broadening of digital literacy, and the expansion of access to scientific knowledge and training can all contribute to increasing people's access to quality health information. In particular, the development and use of mobile devices (mHealth) and electronic health (eHealth) applications have the potential to change the way health services are delivered. The development and implementation of national eHealth strategies will be critical for optimization of the health benefit offered by new information technologies.

4.5 Human Resources for Health

198. Human resources for health—professionals, scientists, technicians, auxiliaries, and community health workers—are the backbone of health systems and services. As such, they are central to the achievement of universal health coverage. Without proper attention, however, the health workforce can become a principal obstacle to the achievement of UHC. Many countries in the Region suffer critical shortages of health personnel at the national level, defined as fewer than 25 health workers per 10,000 inhabitants. Almost all the countries have a scarcity of health workers in certain districts or communities, typically urban fringe or rural communities populated by indigenous people or others with socioeconomic or cultural differences. In the medium term, increasing demands related to noncommunicable diseases and population aging, combined with financial pressures on health systems, will intensify tensions around the

availability, distribution, composition, competencies, management, and performance of health human resources. An additional problem in many countries is outmigration of the health workforce.

199. The health workforce is also a key political actor, with enough power to change the way health policies are formulated and applied. The effectiveness of health care depends greatly on the performance of the health workforce and consequently on its financing, training, selection, contracting, and development by means of comprehensive career pathways. High-quality, people-centered, integrated health services need the right mix of health care workers, with the right skills, in the right place, at the right time. Strengthening the management and development of human resources in health should be part of health public policies. Twenty of the thirty countries that participated in the Mid-term Evaluation of the Health Agenda for the Americas in 2012 reported including this area of work in their national health plans. Because human resources for health can significantly affect population health status, they should be seen as essential workers and not as a flexible resources that can easily be cut in response to a budget shortfall. Health workers are the head, heart, and hands of the health system.

Key Stakeholders' Analysis

200. The health sector has many stakeholders at the global, regional, national, and local levels. Also, in recent years an increasing number of players have emerged in the field of international health; this has fostered constructive cooperation but also competition for resources and for influence on health policy. Improving health and health equity in the Americas requires a shared vision, a rights-based approach, and the alignment of all efforts toward the achievement of common goals. In championing UHC and supporting Member States in their efforts to attain this goal, the PASB will continue its collaboration with the public sector, the private sector, and civil society. Within the public sector, PASB will continue engaging allies in cooperative actions across multiple sectors, including education, agriculture, environment, planning, finance, the legislature, and the judiciary. To avoid duplication, optimize the use of resources, and increase synergies, PASB will continue strengthening coordination with other agencies of the UN and the inter-American systems and improving the harmonization and alignment of the three levels of WHO.

201. PASB will engage with a host of strategic partners involved in the different program areas under this category. They include, among others, the Canadian International Development Agency (CIDA), Public Health Agency of Canada (PHAC), Health Canada, United States Agency for International Development (USAID), United States Department of Health and Human Services (HHS), U.S. Food and Drug Administration (FDA), Spanish Agency for International Development Cooperation (AECID), Escuela Andaluza de Salud Pública (EASP), Government of Brazil, Oswaldo

Cruz Foundation (Fiocruz), Caribbean Public Health Agency (CARPHA), UK Department of Health, Bill and Melinda Gates Foundation, GAVI Alliance, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), World Bank, Inter-American Development Bank (IDB), and RAD-AID International. Finally, PASB will strengthen its relationships and partnerships with WHO Collaborating Centers related to the category, as well as its relationships with numerous professional and academic associations, nongovernmental organizations, and private sector organizations in the area of health systems.

Strategies for Technical Cooperation

(a) Establish partnerships and networks with all branches of government, civil society, universities, research centers, collaborating centers, professional associations, donors, and others to champion universal health coverage.

(b) Apply the primary health care-based approach to health systems transformation as defined in the 2007 PAHO position paper, "Renewing Primary Health Care in the Americas." A PHC-based health system entails an overarching approach to the organization and operation of health systems that makes the right to the highest attainable level of health its main goal, while maximizing equity and solidarity. Such a system is guided by the principles of responsiveness to people's needs, quality, government accountability, social justice, sustainability, social participation, and intersectoral coordination.

(c) Translate research into public health policies that support UHC, implementing PAHO's Policy on Research for Health, the WHO Strategy on Research for Health, and the WHO Strategy on Health Policy and Systems Research. Build and sustain the necessary capacity for conducting research on issues of national and regional interest in the areas of public health, health policies and regulation, and health systems, and translate the findings into policy and practice.

(d) Build capacity for strengthening the steering role of national health authorities and brokering alliances among government institutions and other relevant stakeholders and partners in order to enhance country ownership of national goals and objectives.

(e) Build capacity of the national health authorities in the definition, implementation, monitoring, and evaluation of national health strategies and plans, supported by multisectoral policies and national investments.

(f) Strengthen parliamentary capacity, at both regional and national levels, for developing legislation to achieve UHC.

(g) Promote institutional development and evidence-informed policy options to build legal frameworks and financial mechanisms that increase social protection in health.

(h) Expand the use of information and communication technologies and social media for virtual collaboration and increased outreach of technical cooperation efforts, making use of regional initiatives such as the Primary Health Care Collaborative Network, the Regional Platform on Access and Innovation for Health Technologies, the Virtual Campus for Public Health, and the Regional Observatory of Human Resources in Health.

(i) Provide advocacy and support to Member States in the reorganization of health care by applying the Integrated Health Services Delivery Networks framework (PAHO 2010) and strengthening management and leadership capacities.

(j) Strengthen institutions at the national, subregional, and regional levels and promote a public health approach to development, innovation, incorporation, assessment, regulation, management, and rational use of health technologies with a view to ensuring patient safety and quality of care. Implement the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property, and strengthen the Health Technology Assessment Network of the Americas and the PAHO Strategic Fund for medicines and public health supplies.

(k) Develop and apply evidence-based international norms and standards, methods, analytical tools, and policy options for health systems, services, and health technologies, including health analysis, research, and intervention design and evaluation. Expand knowledge translation platforms that introduce a systematic approach to policy development informed by evidence. Use validated systems to address unjustified or unwanted variations in health care.

(l) Consolidate, maintain, and expand regional initiatives for the strengthening of information systems and information sharing, such as the Regional Plan of Action for Strengthening Vital and Health Statistics (PEVS) and the Regional Core Health Data and Country Profile Initiative. Promote the mapping of national health research systems and other tools to support health research governance and the PAHO Health Information Platform.

(m) Implement the regional strategies and actions plans on e-Health and Knowledge Management and Communications to contribute to the realization of societies that are more informed, equitable, competitive, and democratic.

(n) Develop and implement evidence-based policy options and tools to address the five challenges in human resources development for health set out by the Toronto Call to Action for a Decade of Human Resources in Health in the Americas.

Cross-Cutting Themes and Strategic Approaches in Health

202. Health systems and services are the means to combat disease, promote physical and mental health, and lengthen life. They must guarantee the right to health without discrimination of any kind. They are also a means to promote social and economic

development. Building and maintaining strong health systems based on primary health care is the way to achieve and sustain better health outcomes, improve equity and social protection in health, and enhance people's satisfaction with their health care. Inter-programmatic work and intersectoral collaboration are inherent parts of the PHC strategy. Constraints at the system and service levels can make it difficult to improve health outcomes, and understanding and addressing these constraints requires dialogue and collaboration with experts in all other areas of work. Improving health outcomes with equity requires application of the human rights, gender, and cultural diversity approaches in the development of health systems and above all in assessing their performance.

203. Integration of services across the whole health care continuum and better links between medical, social, and long-term care offer significant benefits in addressing communicable and noncommunicable diseases, maternal and child health, and the health of aging populations. The growing burden of noncommunicable diseases will have devastating health consequences for individuals, families, and communities and threatens to overwhelm health systems. Public health emergencies, disasters, neglected diseases, and emerging threats to population health require responsive health systems. Multisectoral action is needed to address these burdens and threats and to improve health outcomes with equity.

204. Building robust health systems for UHC is everybody's business. It is also a means to achieve the expected outcomes in the other categories of work—for example, to build capacity and tools for policy coherence in order to mainstream the social determinants of health, or to develop the core capacities required by Member States to comply with the International Health Regulations (such as national legislation, policy, financing, coordination, human resources, and laboratories, among others).

Category 4. Health Systems

Program Areas and Outcomes

(BASELINES AND TARGETS UNDER REVIEW PENDING CONSULTATION WITH COUNTRIES)

4.1 Health Governance and Financing; National Health Policies, Strategies, and Plans

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 4.1 Increased countries' capacity for achieving universal health coverage	OCM 4.1.1	Number of countries and territories that have increased health coverage through social protection mechanisms	4 BRA, CHI, COL, URU	14 BOL, COR, ECU, GUY, HAI, MEX, PAR, PER, VEN
	OCM 4.1.2	Number of countries committing at least 5% of gross domestic product (GDP) to public expenditure for health	10 ARG, ARU, BER, CAN, CHI, COR, CUB, DSM, MON, USA	23 ANU, BAR, COL, CUR, DOM, ECU, ELS, NIC, HON, PAN, PAR, URU

4.2 People-Centered, Integrated, Quality Health Services

Outcome	Ind. #	Outcome Indicator	Baseline	Target 2019 (baseline +)
OCM 4.2 Increased access to people-centered, integrated, quality health services	OCM 4.2.1	Number of countries with increased utilization of first level of care services after implementation of new people-centered models of care	9 BOL, BRA, CAN, CHI, COR, ELS, MEX, PAN, PER	20 ARG, ECU, GUT, GUY, NIC, PAR, SUR, SAL,TRT, URU, USA

4.3 Access to Medical Products and Strengthening of Regulatory Capacity

Outcome	Ind. #	Outcome Indicator	Baseline	Target 2019 (baseline +)
OCM 4.3 Improved access to and rational use of safe, effective, and quality medicines, medical products, and health technologies	OCM 4.3.1	Number of countries that provide medicines included in the national essential medicines list free of charge	16 ANI, BAR, BRA, COR, CUB, DOM, DOR, ECU, ELS, GUY, HON, JAM, PAN, PER, TRT	27 ARG, BAH,BOL, CHI, COL, GUT, HAI, PAR SUR, URU, VEN
	OCM 4.3.2	Number of countries and territories that have increased their regulatory capacity toward functionality for medicines and other health technologies	7 ARG, BRA, CAN, COL, CUB, MEX, USA	26 BOL, CHI, COR, DOR, ELS, ECU, GUT,GUY, HAI, HON, JAM, NIC, PAN, PER, TRT, PAR, SUR, URU

4.4 Health Systems Information and Evidence

Outcome	Ind. #	Outcome Indicator	Baseline	Target 2019 (baseline +)
OCM 4.4 All countries have functioning health information and health research systems	OCM 4.4.1	Number of countries and territories that have increased the coverage and improved the quality of their national health information system	14 ARG, BRA, CAN, CHI, DOR, ECU, ELS, GUT MEX, NIC, PAN, PAR, PER, USA	35 ANI,ANU, BLZ, BOL, BVI,COL, COR, CUB, DOM, GRA, GUY, HON, JAM, MON, SAV, SAL, SCN, SUR, TRT,URU, VEN
	OCM 4.4.2	Number of countries with functional mechanism for governance of health research	3 BRA, MEX, PER	14 ARG, BOL COL COR, CHI, ECU, ELS, GUT,HON, PAN, PAR

4.5 Human Resources for Health

Outcome	Ind. #	Outcome Indicator	Baseline	Target 2019 (baseline +)
OCM 4.5 Adequate availability of a competent, culturally appropriate, well regulated and distributed, fairly treated health workforce	OCM 4.5.1	Number of countries facing health workforce shortages	14 BLZ, BOL, COL, DOR, ECU, ELS, GUT, GUY HAI, HON, JAM, NIC, PAR, PER	6 BOL, GUT, GUY, HAI, HON, NIC
	OCM 4.5.2	Number of countries with 100% of primary health care workers having demonstrable public health and intercultural competencies	4 CUB, GRA, COR, NIC	17 ARG,BLZ, BRA,CAN, CHI, DOR, ECU, ELS, GUT, HON, MEX, PAN, PER
	OCM 4.5.3	Number of countries that have reduced by half the gap in distribution of health personnel between urban and rural	9 ARG, BAR, CHI, DOM, JAM, MOT, NIC, SAL, TRT	18 ANI, BLZ, BOL, COL, ECU, GRA, PAN, PAR, PER

Category 5 - Preparedness, Surveillance, and Response

Reducing mortality, morbidity, and societal disruption resulting from epidemics, disasters, conflicts, and environmental and food-related emergencies by focusing on risk reduction, preparedness, response, and recovery activities that build resilience and use a multisectoral approach to contribute to health security.

Scope

205. This category focuses on strengthening countries' capacities in prevention, risk reduction, preparedness, surveillance, response, and early recovery in relation to all types of hazards to human health that may result from emergencies or disasters, with particular attention to capacities that come under the requirements of the International Health Regulations (IHR) 2005. This category aims to strengthen hazard-specific capacity building in relation to a range of diseases with the potential to cause outbreaks, epidemics, or pandemics, and also in relation to food safety-related events, zoonoses, antimicrobial resistance, chemical and radiological emergencies, natural hazards, and conflicts. It considers the human security approach to building coherent intersectoral policies to protect and empower people to increase community resilience against critical and pervasive threats. In addition, this category addresses adequate and coordinated international health assistance to Member States to respond to emergencies when required.

Context

5.1 Alert and Response Capacities

206. As of June 2012, 29 of the 35 State Parties to the IHR 2005 in the Region of the Americas had requested and obtained an extension to implement their core capacities for the surveillance and response components of the IHR 2005. The status of core capacities in the Region is quite heterogeneous across countries, but the most critical weaknesses identified in the reports to the 65th World Health Assembly (WHA) relate to radiation emergencies, chemical events, points of entry, human resources, and preparedness.

207. The aim of this program area is to ensure that all countries of the Region have the core capacities needed to fulfill their responsibilities under the IHR 2005 prior to the deadline in 2016. These cover national legislation, policy, and financing; coordination and national focal point communications; surveillance and risk communication; preparedness and response; infection prevention and control; human resources; and laboratory capacity building and networking. PAHO will provide the countries of the

Region with support for their national efforts to implement their national IHR plans and maintain their capacities.

208. In addition, PAHO as the regional contact point for IHR will continue to develop its ability to detect and verify risk and coordinate risk assessment; disseminate accurate and timely information on potential public health events of international concern; and coordinate response to outbreaks when they arise. This includes providing technical guidance and support through the Global Outbreak Alert and Response Network (GOARN) and other mechanisms.

5.2 Epidemic- and Pandemic-Prone Diseases

209. Epidemic- and pandemic-prone diseases are an ongoing and continuous threat to global and regional health security and sustainable socioeconomic development. The need for comprehensive surveillance and a collective rapid response in the Region, especially to potential pandemics and outbreaks, is a major challenge due to high population movements, changes in environmental settings including deforestation, and climate change, among other factors. Diseases of animal origin can cause epidemics and/or pandemics, pointing to the need for effective risk management of emerging zoonoses and high-impact animal diseases that can cause public health emergencies.

210. Work in this program area will *(a)* improve the sharing of knowledge and information available on emerging and reemerging infectious diseases; *(b)* enhance surveillance and response to epidemic diseases of potential international concern, such as influenza, yellow fever, viral hemorrhagic fevers, SARS, cholera, pneumonic plague, and meningococcal disease and the surveillance of antimicrobial resistance, among others; *(c)* support countries in improving their preparedness, response, and resilience to epidemics, including laboratory capacity strengthening and networking; *(d)* provide guidance on evidence-based clinical management and infection control to reduce morbidity and mortality during outbreaks *(e)* contribute to global mechanisms and processes aimed at managing the international dimension of epidemic diseases, such as the Pandemic Influenza Preparedness Framework and the Global Task Force on Cholera Control.

5.3 Emergency Risk and Crisis Management

211. Between 2006 and 2010, almost one-quarter of the world's disasters occurred in the Americas (442 of 1,915), affecting 48 million people in the Region. The economic impact of these disasters on the Region exceeded US$ 157 billion, equivalent to 34% of the world's total losses. Between 2000 and 2009, more than 45 million people in the Americas remained without health care for months, and sometimes even years, due to damage caused by natural hazards to hospitals and other health facilities.

212. The health sector has the responsibility to monitor, anticipate, and mitigate the health consequences of all types of emergencies and disasters. Toward this end, it must strengthen its capacity to respond with effectively and timely interventions. A major challenge is readiness: the regular operating infrastructure, personnel, and organization of the health services need the flexibility and capacity to immediately shift into emergency response, taking into consideration laboratory, monitoring, personal protective equipment, human resources, and community participation, among other aspects.

213. The Plan of Action on Safe Hospitals aims to protect the lives of patients and health workers, shield health equipment and supplies from disasters, and ensure that the health services continue operating effectively during and after emergencies and disasters in order to save lives, reduce disabilities, and enable the health sector to fulfill its continuing responsibilities.

214. The incorporation of the human security concept into country health plans aims to address the roots of the multiple, interrelated, and widespread threats that endanger the survival, livelihood, and dignity of people. It seeks to increase intersectoral consistency between national-level protective measures and other State policies, local health care, and the empowerment of individuals and communities, especially those in situations of greatest vulnerability.

215. This program area aims to build the capacity of countries to protect the physical, mental, and social well-being of their populations and rapidly recover from emergencies and disasters. This requires adequate national leadership and sustained capacity of the health sector to build the resilience of countries and territories.

5.4 Food Safety

216. In recent times, in both developing and industrialized countries, there has been a growing demand for expertise in the control of food safety and zoonotic diseases in emergency and disaster situations. This knowledge, which is part of the field of veterinary public health (VPH), is fundamental for preparedness, surveillance, and effective response to public health emergencies related to food safety.

217. Food contamination with microbial agents and chemicals (including antimicrobials) is associated with illnesses ranging from diarrheal diseases to various forms of cancer; it thus represents an important public health risk. PAHO has had a regional information system for foodborne disease (FBD) outbreaks in Latin America and the Caribbean since 1993. A study of FBD outbreaks reported by 22 countries from 1993 to 2010 found that of the 9,180 outbreaks where the causative agent was identified, 69% were bacterial and 9.7% viral; 9.5% were caused by ocean toxins, 2.5% by chemical contaminants, 1.8% by parasites, and 0.5% by vegetable toxins. Although data on

foodborne diseases in LAC are limited by underreporting, these figures show the importance of the problem. The United States alone accounts for 47.8 million cases of foodborne disease per year. The WHO also estimates that, depending on the country, 15% to 79% of all cases of diarrhea worldwide are due to contaminated food. Studies in the Region of the Americas show that the relative frequency of diarrheal diseases attributable to foodborne pathogens varies from 26% to 36%.

218. A multisectoral, transdisciplinary approach is necessary to ensure food safety while effectively managing the health risks for humans, animals, plants, and the environment. Intersectoral public policies, strategies, and plans for health, agriculture, and environment are critical to strengthening food safety systems to ensure safe, healthy food, from farm to fork. This should include consumer protection, with an emphasis on poor and vulnerable populations.

5.5 Outbreak and Crisis Response

219. The influenza A (H1N1) pandemic in 2009 and the devastating earthquake in Haiti in 2010, followed by the Haitian cholera epidemic, resulted in enormous emergency response operations that were among the most complicated and challenging ever undertaken by the countries affected, by first responders, and by the entire international community.

220. For the most part, the countries in the Region can now respond to minor disasters in a self-sufficient manner. That said, external assistance will always be necessary during major disasters. The Organization will continue to play an important role in assisting countries and territories in responding to major disasters, guided by the PASB Institutional Response to Emergencies and Disasters policy; thus PAHO must continuously enhance its capacity to initiate assistance in the shortest time possible. Particular attention should be given to ensuring equitable access to health by the most vulnerable populations, including children and the elderly, indigenous communities, and pregnant women, among others.

Key Stakeholders' Analysis

221. Participation of stakeholders, particularly the ministries of health and the national emergency management institutions, is essential to implement the planned activities and achieve outputs and outcomes in this category. All national and international health-related institutions play a key role in strengthening countries' capacities to reduce the risks of, prepare for, respond to, and recover from public health emergencies and disasters.

222. The UN International Strategy for Disaster Reduction, the UN Office for the Coordination of Humanitarian Affairs, and the Inter-Agency Standing Committee are in charge of coordinating global efforts to reduce mortality, morbidity, and societal disruption from disasters. They regularly include health-related priorities in their deliberations, decisions, and guidelines. Current activities that are part of existing multilateral, international, and regional frameworks and mechanisms will be fully implemented, particularly those of the International Health Regulations (2005), the Pandemic Influenza Preparedness Framework, the Global Action Plan for Influenza Vaccines, the Hyogo Framework for Action 2005-2015, the United Nations Transformative Agenda, the Codex Alimentarius Commission, the International Food Safety Authorities Network, the tripartite WHO-FAO-OIE One Health initiative, the International Association for Conflict Management, and the Global Polio Eradication Initiative, as well as chemical conventions and global and regional platforms for disaster risk reduction. Major networks such as the Global Outbreak Alert and Response Network, the Global Influenza Surveillance and Response System, the Inter-Agency Standing Committee's Global Health Cluster and regional response teams will be maintained and strengthened.

223. The stakeholders in food safety include all constituencies with an interest in using food safety information for decision making, research, and advocacy in relation to different parts of the food chain. These include Member States, bilateral and multilateral organizations, the UN and other international organizations, foundations, scientific networks, research institutions, consumer groups, the mainstream and scientific media, as well as the food, agricultural, and pharmaceutical industries.

224. Many universities, centers of excellence, and professional associations, among others, implement research and training activities on management of public health emergencies. These contribute to the development, dissemination, and application of policies, strategies, action plans, technical guidelines, and publications by PAHO Member States and the Secretariat.

Strategies for Technical Cooperation

225. The approach to emergency risk management must be comprehensive, efficient, and effective. Building resilience and protecting populations requires a holistic, coordinated, multi-hazard approach, applied within the Secretariat and across Member States and the international health community. For optimal impact, this approach must be integrated into comprehensive national plans for emergency risk management that involve all sectors. In addition, it will require the development of multisectoral policies and science-based measures to prevent exposure to contaminants through the food chain and ensure the safety of new technologies.

226. The leadership role of the ministries of health will be supported through an increased focus on capacity building for the incorporation of preparedness, surveillance, and response criteria into national policies, plans, norms, standards, and budgets. New emphasis will be placed on the development of linkages with research and academic institutions to better understand the potential impacts of specific hazards such as pandemic influenza, earthquakes, floods, hurricanes, chemical and radiological emergencies, foodborne illnesses, and climate change. Integration of disaster risk reduction in the health sector is essential in order to protect the health services (in terms of both physical infrastructure and functions) and ensure their continuity during and after emergencies.

227. Emphasis will be placed on the use of existing and new health partnerships and disaster management networks, within and external to the health sector, involving other public sector agencies and the private sector. Collaborative activities will include advocacy, information management, resource mobilization, and national and international agreements to reduce the risks of disasters and emergencies and ensure timely and effective health interventions during and after these events. The Secretariat will foster intercountry collaboration, building on countries' specific experiences and capacities. The Secretariat will also increase political awareness on the relevance of infection prevention and control programs within the framework of IHR core capacities.

228. The Secretariat will build internal capacity to further improve its coordinated response mechanisms to prepare for disasters and emergencies and efficiently assist countries when required. In addition, it will implement WHO standard operating procedures for the management of acute public health threats across the Organization (including strengthening the WHO's organization-wide event management system and ensuring operational capacity at all times) and the policy and procedures set forth in the PAHO Institutional Response to Emergencies and Disasters. A lessons-learned approach will be adopted to revise and update the Organization's emergency and disaster policies, procedures, technical guidelines, and other tools and adjust its strategies when needed.

Cross-Cutting Themes and Strategic Approaches in Health

229. Joint planning and execution between all program areas within Category 5 is essential to implement the Strategic Plan. Specific references to cross-cutting themes and strategic approaches are reflected in the descriptions below of linkages with the other categories of work and their specific program areas.

230. This category has particularly strong linkage with Category 1, which is concerned with reducing the burden of communicable diseases. The surveillance and control of these diseases is a major aspect of PAHO's response to humanitarian emergencies and of its responsibilities under the IHR (2005). The Organization's contribution includes expert

guidance on the management of pneumonia, diarrheal diseases, vaccine-preventable diseases, malaria, dengue, viral hepatitis, tuberculosis, and HIV infection in such settings.

231. As far as Category 2, concerned with noncommunicable diseases, coordination with the program area on mental health is necessary to prepare for and respond to the mental health and psychosocial needs of populations affected by disasters and emergencies. As injuries and violence usually increase in emergency contexts, Category 5 has strong links with this program area, which includes prevention of injuries and violence and provision of trauma care. An adequate disaster response will diminish long-term disabilities when appropriate strategies are in place. Strategies to prevent foodborne diseases will also help avoid chronic disabilities such as reactive arthritis or uremic hemolytic syndrome as well as growth retardation associated with diarrhea, an important contributor to stunting in children under age 5. Close links exist between food safety and nutrition in an emergency preparedness context.

232. The Category 3 principles of human rights, equity, gender and ethnic equality, sustainable development, human security, and accountability inform all of the Organization's emergency work. In times of disaster, collaboration is required with program areas addressing the life course, especially with respect to protection and continuous care of pregnant women, children, and the elderly. Elderly populations, in particular, may have reduced mobility and capacity to adapt. Gender roles require explicit consideration in emergency plans and programs. Moreover, risks are distributed along a social gradient, and interventions should especially consider those populations that are marginalized, culturally different, or in situations of vulnerability. The building of community resources to address emergencies is part of the participatory process that must inform a coherent State protection action. Emergency response needs the institutional capacity to identify and manage environmental sanitation, chemical and radiologic threats, and the impact from climate change.

233. The capacities required for risk reduction, disaster preparedness, response, and recovery, and to comply with the IHR, are fundamental components of Category 4 (Health Systems). A strong link with national health policies, strategies, and plans is needed to facilitate the implementation of resolutions and mandates regarding the IHR 2005, the Plan of Action on Safe Hospitals, food safety policies and regulations, and the United Nations reform in the area of disaster management. Full alignment with the integrated, people-centered health services approach is key to providing humanitarian assistance and outbreak response. Access to medical products and strengthening regulatory capacity, particularly radiologic emergencies and laboratories are key aspects in relation to emergency preparedness, IHR, and crisis response. Health system information and evidence will provide critical data to elaborate risk assessments, monitor progress, generate science-based intervention measures, and implement emergency response. One of the pillars of emergency preparedness is to strengthen the capabilities of

human resources in health in order to implement timely and adequate response to the public health consequences of emergencies and disasters.

234. With respect to Category 6, the Secretariat will use partnerships to provide support to countries in enhancing their emergency risk management capacities. WHO will strengthen its interaction with other organizations in the United Nations system and with multilateral, bilateral, and regional agencies. Emergency response requires a specific risk communication strategy, built by those responsible for management of the response, and a well-defined set of communication channels, messages, and methods for reaching target groups. A large part of the work of Category 5 depends on organizational leadership processes related to strategic planning, resource mobilization, and resource management (especially access to extrabudgetary resources). The development, negotiation, and implementation of new approaches to financing, designed to increase the predictability, flexibility, and sustainability of PAHO's financing, is therefore central to the work in this category. Critical to the effective and efficient functioning of Category 5 is the existence and application of flexible, achievement-oriented administrative processes, especially for work in emergency contexts.

Category 5 - Preparedness, Surveillance, and Response

Program Areas and Outcomes

(BASELINES AND TARGETS UNDER REVIEW PENDING CONSULTATION WITH COUNTRIES)

5.1 Alert and Response Capacities

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 5.1 All countries have the minimum core capacities required by the International Health Regulations (2005) for all-hazard alert and response	OCM 5.1.1	Number of countries meeting and sustaining International Health Regulations (IHR) 2005 requirements for core capacities	6 BRA, CAN, CHI, COL, COR, USA	35 ANI, ARG, BAH, BAR, BLZ, BOL, CHI, CUB, DOR, DOM, ECU,ELS, JAM, GRA, GUT, GUY, HAI, HON, MEX, NIC, PAN, PAR, PER, SAL, SAV, SCN, SUR, TRT, URU, VEN

5.2 Epidemic- and Pandemic-Prone Diseases

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 5.2 All countries are able to build resilience and adequate preparedness to mount a rapid, predictable, and effective response to major epidemics and pandemics	OCM 5.2.1	Number of countries with installed capacity to effectively respond to major epidemics and pandemics	6 BRA, CAN, CHI, COL, COR, USA	35 ANI, ARG, BAH, BAR, BLZ, BOL, CHI, CUB, DOM, DOR, ECU, ELS, GRA, GUT, GUY, HAI, HON, JAM, MEX, NIC, PAN, PAR, PER, SAL, SAV, SCN, SUR, TRT, URU, VEN

5.3 Emergency Risk and Crisis Management

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 5.3 Countries have an all-hazards health emergency risk management program for a disaster-resilient health sector with emphasis on vulnerable populations	OCM 5.3.1	Number of countries and territories that meet or exceed minimum capacities to manage public health risks associated with emergencies addressing vulnerable communities	14 ARG, ARU, BRA, CAN, CHI, COL, ECU, FRG, GUA, GUT, MAR, PER, USA, VEN	36 ANI, BAH, BAR, BLZ, BOL, COR, CUR, DOM, DOR, DSM, ELS, GRA,GUY, HON, JAM, NIC, PAN, SAL, SVN, SUR, TRT, URU
	OCM 5.3.2	Number of countries implementing disaster risk reduction interventions in the health sector that increase community resilience	12 ARG, BAR, CAN, CHI, COL, DOR, ECU, ELS, GUT, MEX, PER, USA	35 ANI, BAH, BLZ, BRA, BOL, COR, CUB, DOM, GRA, GUY, HAI, HON, JAM, NIC, PAN, PAR, SAL, SAV, SCN, SUR, TRT, URU, VEN

5.4 Food Safety

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 5.4 All countries have the capacity to mitigate risks to food safety and to respond to outbreaks	OCM 5.4.1	Number of countries and territories that have adequate mechanisms in place for preventing or mitigating risks to food safety and for responding to outbreaks, including among marginalized populations	4 CAN, CHI COL, USA	38 List of countries to be included after national consultation

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
	OCM 5.4.2	Number of countries with risk management mechanisms for ***high impact animal diseases affecting public health, including emerging foodborne zoonotic diseases*** (animal health subject to budget confirmation)	3 CAN, CHI, USA	38 List of countries to be included after national consultation

5.5 Outbreak and Crisis Response

Outcome	Ind. #	Outcome Indicators	Baseline 2012	Target 2019 (baseline +)
OCM 5.5 All countries adequately respond to threats and emergencies with public health consequences	5.5.1	Percentage of countries that demonstrate adequate response to an emergency from any hazard with a coordinated initial assessment and a health sector response plan within 72 hours of onset	N/A	100%

Category 6 - Corporate Services/Enabling Functions

Fostering and implementing the organizational leadership and corporate services that are required to maintain the integrity and efficient functioning of the Organization, enabling it to deliver effectively on its mandates.

Scope

235. This category includes functions and services that contribute to strengthening PAHO's leadership and governance, as well as transparency, accountability, and risk management. It also seeks to enhance strategic planning, resource coordination, resource mobilization and reporting, management and administration, and strategic communications. The work in this category will continue to strengthen PAHO's leading role in the Region to enable the many different actors to play active and effective roles in contributing to the health of all people. It will also result in an Organization that is responsive and transparent, and will enhance the work of the PASB in supporting the delivery of technical cooperation in all categories in an effective and efficient manner. The work under this category will be important to improve coordination with national authorities, UN agencies and other intergovernment organizations, public-private partnerships, and civil society in line with the UN Quadrennial Comprehensive Policy Review.

Context

6.1 Leadership and Governance

236. In the Organization's efforts to champion health and address the health inequities of the Region, the PASB must exercise keen leadership in collaboration with countries and partners. Consequently, this program area addresses the following issues: *(a)* reinforcing leadership in health to support Member States in their governance role within the framework of WHO and UN reform; *(b)* coordinating and convening relevant stakeholders in health to ensure good governance and accountability to Member States; *(c)* reinforcing Member States' efforts to fulfill regional priorities in health, as detailed in this Plan as well as within the Health Agenda for the Americas 2008-2017; and *(d)* strengthening country presence to efficiently and effectively address national health needs. These efforts should lead to intersectoral action that moves from a focus on disease to a focus on well-being and sustainable development.

237. The increasing number of players in health is a continuing trend that is not expected to wane in the foreseeable future. It has led to new partnerships, alliances, financing channels, and sources of technical support. At the same time, the growing

number of stakeholders creates challenges related to duplication of efforts, high transaction costs, varying accountability requirements, and inconsistent alignment with approved national and regional priorities, such as those defined in the Health Agenda for the Americas 2008-2017.

238. In addition, some emerging economies are increasing their financial and technical support for health beyond their national programs as part of a growing trend in South-South and similar forms of cooperation. Recognizing the rich expertise to be found in Member States, PAHO is increasingly drawing upon this resource to support technical cooperation. This Pan American approach is key in reinforcing the work of Member States and of the Organization.

239. PAHO must be able to respond to the evolving needs of the countries and adapt to external changes such as those stemming from WHO and UN reform. It therefore needs to continue efforts to increase the effectiveness of its engagement with other stakeholders, strengthen the negotiation capacity of health actors, invest in health diplomacy, and utilize its leadership position to enhance coherence among the many actors involved in health at the global, regional, subregional, and national levels. This coherence may be evident, when appropriate, within the UN Development Assistance Framework (UNDAF) or other similar initiatives. In this regard, the Organization will need to reinforce and refine its work across the three functional levels—national, subregional, and regional—and increase the harmonization and coordination with WHO.

240. The following nine PASB leadership priorities support the implementation of the Plan. The PASB will advocate for these priorities to be addressed at the highest political levels and for the necessary actions to take place at national, subregional, and regional levels. In doing so, the Bureau will refine existing strategies, including the implementation of new modalities of technical cooperation, and build capacity in health diplomacy and health governance. [UNDER REVIEW].

(a) Strengthen health sector capacity to address the social determinants of health, promoting increased community participation and empowerment.

(b) Catalyze the progressive realization of universal health coverage, with emphasis on the eight priority countries.

(c) Increase intersectoral and multisectoral action for prevention and care of noncommunicable diseases.

(d) Enhance countries' core capacities to implement the International Health Regulations of 2005.

(e) Accelerate actions for the elimination of priority communicable diseases in the Region.

(f) Conclude the work on the health-related MDGs and influence the integration of health in the post-2015 agenda for sustainable development.

(g) Strengthen health system capacity to generate information and evidence to measure and demonstrate progress in healthy living and well-being.

(h) Optimize the knowledge and expertise in countries of the Region in the provision of technical cooperation.

(i) Increase accountability, transparency, efficiency, and effectiveness of the Bureau's operations.

241. To ensure that PAHO remains relevant as a leading public health organization that is responsive to its Member States, strengthening the governance of the Organization is an ongoing priority. This requires the continuous engagement and oversight of Member States through the formal mechanisms of the PAHO Governing Bodies and through close collaboration at country level.

6.2 Transparency, Accountability, and Risk Management [UNDER REVIEW]

242. Managerial transparency, accountability, and risk management are key aspects of effective and efficient management and instill trust and confidence in the work of the Organization on the part of our Member States, donors, stakeholders, and partners. Toward this end, PAHO will strengthen existing mechanisms and introduce new measures designed to ensure that the Organization continues to be accountable, transparent, and adept at effectively managing risks.

243. Evaluation is a key aspect of addressing transparency and accountability, and facilitates conformity with best practice. PAHO/WHO will work to foster a culture of evaluation and its proactive use throughout the Organization. This entails providing a consolidated institutional framework for evaluation across the different levels, in keeping with the norms and standards of the United Nations Evaluation Group. PAHO will address its specific needs in this area within the context of the WHO evaluation policy. In addition, PAHO will continue to strengthen a culture of evaluation as an integral component of operational planning, backed by a quality assurance system to promote best practices. A coordinated approach and ownership of the evaluation function will be promoted at all levels of the Organization. Objective evaluation will be facilitated, in line with a proposed PAHO evaluation policy, and will be supported by tools such as clear guidelines.

244. The internal audit function in PAHO has been significantly strengthened in the past few years. The Organization will continue to perform audits of its operations, at headquarters and in the PAHO/WHO Representative Offices, that take into account specific risk factors. The Ethics Office will continue to focus on strengthening standards

of ethical behavior by staff and will perform risk assessments to identify any vulnerabilities that may affect the image and reputation of the Organization. Specific emphasis will be given to the elaboration of a new conflicts of interest and financial disclosure program. As the coordinator of PAHO's Integrity and Conflict Management System, the Ethics Office will also lead efforts to further strengthen the internal justice system in PAHO.

245. Managing risks is an important area of focus. PAHO is continuously exposed to risks of varying types, including those related to its technical work in public health; its financing; its procurement activities on behalf of Member States; its relationships with the private sector, nongovernmental organizations, and other institutions; and the political and governance context. All have the potential to affect the Organization's effectiveness and reputation. This approach requires established processes to be put in place and monitored to ensure that all risks are properly identified and managed and reported regularly to PAHO's senior management to enable informed decisions and actions to be taken on a timely basis.

246. To ensure the effective working of the risk management system and of compliance and control activities, PAHO will operationalize an Enterprise Risk Management (ERM) system at all levels of the Organization. This is aligned with the work being done by the WHO Independent Expert Oversight Advisory Committee.

6.3 Strategic Planning, Resource Coordination, and Reporting

247. This program area encompasses policy development, strategic and operational planning, budget management, performance, monitoring and assessment, and reporting at all levels. It also covers the financing and management of resources to ensure coherence, synergy, and alignment between the different parts of the Bureau in response to the priorities established in the Strategic Plan. PASB continues to advance and consolidate Results-based Management as the central operating framework for the improvement of organizational effectiveness, efficiency, alignment with results, and accountability. Especially important is the development, negotiation, and implementation of new approaches to resource mobilization and partnerships, designed to increase the predictability, flexibility, and sustainability of PAHO's financing, using a programmatic approach.

6.4 Management and Administration

248. This program area covers the core administrative services that underpin the effective and efficient functioning of PAHO: finance, human resources, information technology, procurement, and operations support. The Bureau will seek to implement modern management information system that can simplify administrative processes and

improve performance controls and indicators. This will result in improved efficiency, transparency, accountability, decentralization, and delegation of authority. Furthermore, it will ensure that decision making and resource allocation occur closer to where programs are implemented. In addition, managerial and administrative capacities and competencies will be strengthened at all levels in the PASB.

249. The adequacy of the financial control framework, as a specific aspect of risk management, is a particular priority. PAHO will improve and enhance mechanisms that will allow it to state, with confidence and on time, how all resources invested in the Organization are being utilized to achieve the anticipated results set out in the Strategic Plan and the Program and Budget.

250. The focus in relation to human resources is also in line with the overall management reform. This seeks to ensure that PAHO is able to recruit the right staff and deploy them where they are needed; manage staff contracts in line with existing rules and in ways that encourage mobility and career development; use succession planning to promote the continuity of essential functions; and ensure that the Organization has human resources policies and systems in place that allow it to respond rapidly to changing circumstances and public health needs.

251. Procurement is a key component of the mission of the Organization. Among other things, it supports technical cooperation through the procurement of goods and services on behalf of Member States, ensuring their access to affordable drugs, vaccines, and other public health supplies. The Organization has procurement policies and procedures and organizational planning systems in place to ensure appropriate management of strategic and transactional activities and to allow rapid response in case of emergencies.

252. PAHO will ensure a safe and healthy working environment for its staff through the effective and efficient provision of operational and logistics support, infrastructure maintenance, and asset management, including compliance with United Nations Minimum Operating Security Standards (MOSS) and Minimum Operating Residential Security Standards (MORSS).

253. Finally, the development and implementation of policies and services for information technology will continue to ensure fully functional infrastructure, applications, networks and communications, end-user support, and business continuity.

6.5 Strategic Communications

254. Work in the area of strategic communications will be based on two interlinked objectives. On one hand, PAHO plays a crucial role in providing the public with timely and accurate health information, including during emergencies. On the other hand, PAHO

needs to communicate its own work better, including its impact, to increase its visibility and strategic positioning as a leading health organization.

255. The ever-growing demand for information on health requires PAHO to communicate internally and externally in a timely and consistent way. It also requires the provision of essential health knowledge and advocacy material to Member States, health partners, and other stakeholders, including civil society.

256. PAHO will take a more proactive approach to working with its staff and with the media to better explain the Organization's role and impact on people's health. This will be achieved through implementation of the Knowledge Management and Communications Strategy across all levels of the Organization. Furthermore, PAHO will enhance its capacity to provide health information using innovative communications to reach a broader audience.

257. Key elements of this program area include developing, managing, and sharing evidence-based information and knowledge produced by the PAHO Member States and PAHO Secretariat; providing technical cooperation on knowledge management and communications; facilitating the communications between PAHO and its stakeholders, including the UN and inter-American systems, the general public, and specialized audiences, enhancing the image of the Organization; and using communications to promote the individual, social, and political changes necessary for improvements and maintenance of health and well-being.

Key Stakeholders' Analysis (UNDER REVIEW)

258. Participation and engagement of a broad spectrum of stakeholders is necessary to achieve many of the outcomes and outputs in this category and support the implementation of the Strategic Plan. Recognizing the Organization's role within WHO and the UN, it is anticipated that there will be ongoing and increased coordination, harmonization, and communication with them. This is especially notable as the Organization anticipates positive contributions to successfully implement institutional reforms being undertaken in WHO and the UN. With specific efforts underway on programmatic priority setting and managerial reform, the Organization's interactions with the WHO and UN family will be particularly important. At the country level this will include active engagement of the UN Country Team, at the regional level this will also include the ongoing collaboration between UN agencies to provide synergistic support, and at the global level PAHO will continue to collaborate in the rich policy and technical dialogues.

259. With a view toward implementing new modalities of technical cooperation, broadened country based, and inter-country collaboration and partnerships will include

ministries of health, as well as other key public and private sector stakeholders outside of the health sector. Reaching out to involve other actors will be key to ensure sufficient attention to the determinants of health.

260. The Organization's efforts depend upon resources within a challenging economic environment, where there is significant competition. Nonetheless, the Organization continues to demonstrate important results to partners, thus contributing to ongoing engagement and collaboration. In this regard, the Organization must be poised to foster new partnerships, and reinforce existing alliances, in support of the regional public health agenda. Taking into account the number of middle income countries within the region, the Organization will continue to reinforce and develop financing modalities with Member States, both to support collaboration within individual countries, as well as to focus strategic attention on regional public health issues.

Strategies for Delivering Corporate Services/Enabling Functions

261. The main strategies for delivering the corporate services and enabling functions include the following:

(a) Lead, direct, and coordinate with WHO, Member States, and the UN and inter-American systems, and with other partners, stakeholders, and the general public to ensure greater responsiveness to the health needs of Member States, while advancing regional and global health mandates.

(b) Continue to support and coordinate the development of Country Cooperation Strategies that are closely aligned with national health policies, strategies, and plans, and with UN Development Assistance Frameworks, to reflect greater harmonization.

(c) Promote intersectoral and multisectoral approaches to build institutional capacity and leadership among Member States for their role in health governance.

(d) Guarantee that Member States and other partners are fully engaged and committed to the effort to ensure sustainable resources for the implementation of PAHO's Strategic Plan, through a programmatic approach based on RBM.

(e) Strengthen the appropriate competencies among PAHO staff for launching new approaches in health diplomacy and new partnerships.

(f) Ensure implementation of a modern management information system so that administrative processes are simplified and performance indicators and controls improved, resulting in increased efficiency, transparency, accountability, decentralization, and delegation of authority.

(g) Build institutional capacity for implementing the ERM.

(h) Strengthen managerial and administrative capacities and competencies at all levels of the PASB.

(i) Strengthen human resources strategic planning, focusing on succession planning, staff placement based on competency and needs, staff mobility, and staff development.

(j) Build and sustain the capacity of the Bureau to implement internal communications and knowledge management strategies.

Cross-Cutting Themes

262. Building on existing policies and practices, the cross-cutting themes of gender equity, equity in health, human rights, and cultural diversity will be applied throughout the work of this category as necessary, but especially in matters related to human resources management and the internal justice system. In addition, the Organization will apply the System-wide Action Plan on Gender Equality and Women's Empowerment recently adopted by the United Nations (UN-SWAP).

263. Through the work included in this category, the Bureau will support the work of the other categories to enable the achievement of their results. In this way, Category 6 is linked to all other categories.

Category 6. Corporate Services/Enabling Functions

Program Areas and Outcomes

(BASELINES AND TARGETS UNDER REVIEW PENDING CONSULTATION WITH COUNTRIES)

6.1 Leadership and Governance

Outcome	Ind. #	Outcome Indicator	Baseline 2012	Target 2019 (baseline +)
OCM 6.1 Greater coherence in regional health, with WHO/PAHO playing a leading role in enabling the many different actors to contribute effectively to the health of all people in the Americas	OCM 6.1.1	Level of satisfaction of Member States with WHO/PAHO's role in leading on global and regional health issues	High (based on composite rating from the stakeholders' survey, November 2012)	At least high (stakeholders' survey 2015)
	OCM 6.1.2	Number of national health plans or strategies that incorporate the Areas of Action of the Health Agenda for the Americas (HAA) 2008-2017	20 (from HAA Mid-term Evaluation)	TBD after national consultations
	OCM 6.1.3	Number of subregional health agendas, strategies, or plans that incorporate the Areas of Action of the Health Agenda for the Americas 2008-2017	3 (TBC from HAA Mid-term Evaluation)	5
	OCM 6.1.4	Number of international agencies working in health in the Region using the Health Agenda for the Americas 2008-2017 for designing their policies, plans, or strategies	5 (TBC from HAA Mid-term Evaluation)	10

6.2 Transparency, Accountability, and Risk Management

Outcome	Ind. #	Outcome Indicator	Baseline 2012	Target 2019 (baseline +)
OCM 6.2 PAHO operates in an accountable and transparent manner and has well-functioning risk-management and evaluation frameworks	OCM 6.2.1	Proportion of corporate risks with approved response plans implemented	0	100%

6.3 Strategic Planning, Resource Coordination, and Reporting

Outcome	Ind. #	Outcome Indicator	Baseline 2012	Target 2019 (baseline +)
OCM 6.3 Financing and resource allocation aligned with priorities and health needs of the Member States in a Results-based Management framework	OCM 6.3.1	Percentage of approved PAHO budget funded	80% TBC (based on 12-13 projection)	90%
	OCM 6.3.2	Percentage of outcome indicator targets achieved	89% (TBC based on last Performance Monitoring and Assessment)	90%

6.4 Management and Administration

Outcome	Ind. #	Outcome Indicator	Baseline 2012	Target 2019 (baseline +)
OCM 6.4 Effective management and administration across the three levels of the Organization	OCM 6.4.1	Proportion of management and administration metrics (as developed in service-level agreements) achieved	Data not currently measured	95%

6.5 Strategic Communication

Outcome	Ind. #	Outcome Indicator	Baseline 2012	Target 2019 (baseline +)
OCM 6.5 Improved public and stakeholders' understanding of the work of PAHO/WHO	OCM 6.5.1	Percentage of Member States and other stakeholder representatives evaluating WHO/PAHO performance as excellent or good	77% (May 2013)	100% Stakeholder Perception Survey (November 2019)

VII. Ensuring Efficient and Effective Implementation of the Plan

[UNDER DEVELOPMENT]

264. This section will provide an analysis of the factors that may have a bearing on efficient, effective implementation of the Plan. Among other issues, the section will address the following:

(a) *Strategies for technical cooperation:* This section will provide a summary of the strategies that PAHO will implement to achieve the results anticipated in the Plan. There will be significant attention devoted to the modalities of PAHO/WHO's technical cooperation.

(b) Roles and responsibilities of PASB and PAHO Member States in successful implementation of the Plan: Emphasis will be placed on clarifying the joint actions necessary to achieve the Plan's outcomes and bring about the expected impacts.

(c) Funding the Strategic Plan: A resource envelope will be estimated and included in the Strategic Plan. Its purpose is to provide Member States with a sense of the magnitude of the resources that will be required over the six-year period covered by the Plan to enable achievement of the anticipated results. This will involve reviewing the amount of resources available to implement the PAHO Strategic Plan 2008-2013, with an analysis of existing trends in all funding sources: regular budget (RB), voluntary contributions (VC), national voluntary contributions (NVC), and funds from WHO. Implications of the new PAHO budget policy will be considered, as well as how to incorporate NVCs and deal with them in relation to funding the Plan's categories and outcomes. Special attention will be paid to PAHO's programmatic approach, as guided by this Plan, with a view to obtaining the necessary resources with sufficient flexibility to allow for achievement of the Plan's anticipated outcomes.

(d) Risk management: PASB will apply its Enterprise Risk Management framework to identify the risks and implement mitigation measures required to increase the likelihood of achieving the anticipated results of the SP 2014-2019. The ERM framework is based on the ISO 31000 international standard and includes a methodology for integrating risk management across all levels of the Organization in a proactive, continuous, and systematic process. This process aims to enable the Organization to identify and manage risks in a timely fashion and to successfully take advantage of opportunities that may arise. The ERM framework will be applied to the Strategic Plan 2014-2019, Program and Budgets 2014-2015, 2016-2017, and 2018-2019, and operational planning across all PASB offices.

VIII. Monitoring and Reporting, Assessment, Accountability, and Transparency

[UNDER DEVELOPMENT]

265. PAHO's performance will be assessed by measuring progress toward the attainment of the impact goals and outcomes set out in the Strategic Plan 2014-2019 during the period covered by the Plan.

266. The overall performance of PAHO's SP 2014-2019 will be assessed using defined outcome indicators. Such an assessment will require monitoring and reporting by both PAHO Member States and the PASB. Therefore, it is important that the most relevant and feasible outcome indicators be defined, taking into consideration both the availability of information and the capacity of Member States to report the indicators.

267. In order to measure progress, baselines and targets have been defined for each impact goal and outcome indicator. A list of countries has been identified in the baseline and targets for outcome indicators to assess specific progress in countries and to focus the required interventions. This will contribute to transparency and to the shared accountability and responsibility of Member States and the PASB for the achievement of the anticipated results of the Plan.

268. Monitoring and reporting on the SP 2014-2019 impact and outcomes will make use of PAHO's existing health information system (PAHO's Regional Core Health Data and Country Profile Initiative). This may require strengthening and/or expanding the current data set, including making improvements in Member States' reporting.

269. Performance monitoring and assessment (PMA) for the Plan will be conducted on an annual basis, and a report will be presented to the Governing Bodies at the end of each biennium. The end-of-biennium Program and Budgets performance assessment will provide a comprehensive appraisal of PAHO's performance and will include an assessment of progress made toward achieving the stated outcomes. The end-of-biennium assessments will form the basis for informing Member States on progress made in implementing the Strategic Plan. Work will continue on defining both the PMA framework and process for the new PAHO Strategic Plan, including the level of PASB's accountability and its joint responsibility with Member States to monitor and report on both outcome- and impact-level results.

270. Considering the timelines of the post-2015 development agenda, a mid-term evaluation of the Plan is proposed to inform the necessary adjustments in response to the health aspect of the new agenda.

Acronyms and Abbreviations

Acronym	Description
ACTS	artemisinin-based combination therapies
AECID	Spanish Agency for International Development Cooperation
AIDS	acquired immunodeficiency syndrome
AIDSMR	mortality rate due to AIDS
ALBA	Bolivarian Alliance for the Peoples of Our America
AMR	amenable mortality rate
ART	antiretroviral therapy
BMGF	Bill and Melinda Gates Foundation
BMI	body mass index
BRICS	Brazil, Russia, India, China, and South Africa
BWP	Biennial Work Plan
CAF	Development Bank of Latin America
CARPHA	Caribbean Public Health Agency
CCG	Countries Consultative Group
CCS	Country Cooperation Strategy
CCTs	cross-cutting themes
CDC	U.S. Centers for Disease Control and Prevention
CIDA	Canadian International Development Agency
CKD	chronic kidney disease
CSDH	Commission on Social Determinants of Health
CSIH	Canadian Society for International Health
CVD	cardiovascular disease
cVDPV	circulating vaccine-derived poliovirus
DALYs	disability-adjusted life years

DPAS	Diet, Physical Activity and Health
EASP	Escuela Andaluza de Salud Pública
EC	Executive Committee
eHealth	electronic health
ERM	Enterprise Risk Management
FAO	Food and Agriculture Organization of the United Nations
FBD	foodborne disease
FCTC	WHO Framework Convention on Tobacco Control
FDA	U.S. Food and Drug Administration
Fiocruz	Oswaldo Cruz Foundation
GARC	Global Alliance for Rabies Control
GASP	Gonococcal Antimicrobial Surveillance Programme
GDP	gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GLC	Green Light Committee
GOARN	Global Outbreak Alert and Response Network
GPW	WHO General Programme of Work
H1N1	pandemic influenza A
HAA	Health Agenda for the Americas 2008-2017
HBV	hepatitis B virus
HCV	hepatitis C virus
HDI	Human Development Index
HHS	United States Department of Health and Human Services
HIV	human immunodeficiency virus
HNI	Health Needs Index
HPV	human papillomavirus
HTA	health technology assessment

IAPAC	International Association of Providers of AIDS Care
ICC	interagency coordinating committee
ICTS	information and communication technologies
IDB	Inter-American Development Bank
IHR	International Health Regulations
IICA	Inter-American Institute for Cooperation on Agriculture
IMR	infant mortality rate
IMS-Dengue	Integrated Management Strategy for Dengue Prevention and Control
LAC	Latin America and the Caribbean
Lb	live births
MDG	Millennium Development Goal
MDR-TB	multidrug-resistant tuberculosis
MERCOSUR	Common Market of the South
mHealth	mobile health (via mobile telephones, tablets, etc.)
MMR	maternal mortality ratio
MNCH	maternal, neonatal, and child health
MORSS	Minimum Operating Residential Security Standards
MOSS	Minimum Operating Security Standards
MSM	men who have sex with men
NCD	noncommunicable disease
NID	neglected infectious disease
NVC	national voluntary contributions
OECD	Organisation for Economic Co-operation and Development
OIE	World Organisation for Animal Health
OIRSA	Regional International Organization for Plant Protection and Animal Health
PAFNCD	Pan American Forum for Action on NCDs

PAHO	Pan American Health Organization
PASB	Pan American Sanitary Bureau
PATH	Program for Appropriate Technology in Health
PB 2014-2015	PAHO Program and Budget 2014-2015
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHAC	Public Health Agency of Canada
PHC	primary health care
PMA	performance monitoring and assessment
PMIS	PAHO Management Information System
PNMR	premature noncommunicable mortality rate
PRS	Priority Rating System
RB	regular budget
RBM	Results-based Management
REMSAA	Meeting of Ministers of Health of the Andean Area
SDG	Sustainable Development Goals
SP 2014-2019	PAHO Strategic Plan 2014-2019
SRH	sexual and reproductive health
STI	sexually transmitted infection
SVI	Sabin Vaccine Institute
TB	tuberculosis
TB-HIV	HIV-associated tuberculosis
TCC	technical cooperation among countries
TFGH	Task Force for Global Health
UHC	universal health coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASUR	Union of South American Nations

UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN-SWAP	UN System-wide Action Plan on Gender Equality and Women's Empowerment
USAID	United States Agency for International Development
VC	voluntary contributions
VPD	vaccine-preventable disease
VPH	veterinary public health
WHA	World Health Assembly
WHO	World Health Organization
WSPA	World Society for the Protection of Animals

References [TO BE COMPLETED]

Annexes

Annex I: - *Key Lessons Learned from Previous Plans*

1. The PAHO SP 2014-2019 builds on PAHO's experience and lessons learned from previous plans, programs, budgets, and other high-level planning instruments and processes, including WHO's planning and budgeting processes. Particular attention has been placed on the review of lessons learned from the PAHO SP 2008-2013, given that this was the first plan to be implemented using the results-based management approach.

2. The main lessons learned that were considered in the development of the PAHO SP 2014-2019 are outlined below. They have been divided into three categories, *(a)* political and strategic, *(b)* programmatic and technical, and *(c)* managerial and administrative, to guide their application to key aspects of the implementation of the Plan. The application of these lessons will be essential for the successful implementation of the Plan and for continued improvement in the efficient and effective management of the Organization.

Political and Strategic

3. The PAHO SP 2008-2013 was the first plan that was aligned with WHO's planning and budget processes (specifically the WHO Medium-term Strategic Plan 2008-2013 and its corresponding Program Budgets). Even though the decision was made to align, for the first time, the work of the Organization with the WHO's GPW, the alignment was not fully implemented across different strategic objectives. These variances with the WHO's GPW created some challenges in reporting at the global level. The Strategic Plan 2014-2019 is aligned with the WHO 12th General Programme of Work, preserving the regional specificities, and this level of alignment should facilitate monitoring and reporting on global indicators included in the 12th GPW. Furthermore, it will facilitate the management of resources received from WHO and the contribution of the Region to the global health agenda.

4. The Strategic Plan 2014-2019 should be flexible enough to easily adapt to changing circumstances. The process of modifying the SP 2008-2013 required Member States' approval for all changes, including but not limited to setting baselines and targets that were established for the whole period of implementation. The new Plan incorporates clearer roles and responsibilities of Member States and the PASB. In this regard, it will incorporate mechanisms for making the necessary adjustments in the different components of the Plan during its implementation.

5. Although a strategic document should indicate the priority areas where the Organization will direct its resources, further prioritization within areas is required to

effectively address key issues. When the SP 2008-2013 was prepared, the prioritization criteria were not evidence-based and were not developed through wide consultation; this limited subsequent acceptance of the plan. In the 2014-2019 Strategic Plan, the criteria were developed based on a scientific method and with the involvement of staff from across the PASB. The criteria and methodology were also reviewed and applied by Member States through the Countries Consultative Group (CCG).

6. Achievement of the results of the Strategic Plan should be a joint responsibility of PASB and the Member States. There is a need for a stronger engagement of Member States during all phases, from the inception of the Plan through its implementation and final evaluation. In this regard, the PAHO Strategic Plan 2014-2019 should be implemented within other strategic frameworks, including WHO's GPW and the Health Agenda for the Americas, as well as other relevant frameworks in the Region.

7. National voluntary contributions (i.e., voluntary contributions from Member States solely for technical cooperation in their own country) were a significant portion of the voluntary contributions received by the Organization during implementation of the Strategic Plan 2008-2013. Although an effort was made to ensure appropriate linkages with the strategic priorities established by Member States, there is a need to explicitly identify these contributions to the overall achievement of the results. The Program and Budget 2014-2015 will indicate national voluntary contributions under each category and their effect on other funding sources for the Organization, as well as on the overall balance between resource levels and programmatic achievements.

Programmatic and Technical

8. The Organization has advanced in promoting and supporting the inter-programmatic work among different categories, particularly at country level. Challenges remain at the regional level, where a fixed functional structure seems to hamper horizontal collaboration. The reduction in the number of strategic objectives—now categories—and a more flexible managerial approach are intended to address this challenge. Additional changes will be required at the operational level to encourage work across categories.

9. The strategy of cooperating through networks for the improvement of governance and leadership has been found appropriate and cost-efficient; however, it requires an institutional commitment for medium/long-term sustainability. The creation of networks should include sustainability mechanisms in order to be successful in the long term.

10. Technical cooperation projects among countries using flexible sources of funding, such as the country variable portion of the budget, proved to be more effective than comparable projects without such flexibility. There are many country-specific factors

(political will, economic constraints, and other health priorities) that affect the viability of such projects, and funds therefore need to be adjusted to the specific needs of the Member States. However, this also requires the establishment of criteria to ensure an equitable approach to resource allocation among countries. Member States expressed the need for enhanced knowledge sharing among public health practitioners as well as international cooperation agencies, which led to a cross-organizational effort to create a web-based knowledge sharing platform where experiences and good practices in public health can be shared. The growing importance of South-South and triangular cooperation in the international dialogue has led the Organization to develop a political framework for the facilitation of cooperation among countries. This will be reviewed by the Governing Bodies in 2013 and potentially incorporated into the new Strategic Plan, if approved.

11. The subregional level of technical cooperation was introduced with the Regional Program Budget Policy in 2006. It was designed to enable the Organization to support the health plans of the subregional integration processes in the Americas, providing an additional space for cooperation and advocacy in the Region. Work at this level has given the Organization additional space and flexibility to respond to Member States' needs while simultaneously encouraging intercountry cooperation, which is a topic of growing importance among countries in the Region. Technical cooperation at the subregional level also facilitates the subregional, regional, and global health policy debates by creating a variety of diplomatic forums in which countries can contribute to supra-national health policy dialogue and diplomacy. Each subregional process offers a platform for common interests and concerns, as well as a space where innovative policies and practices can emerge through dialogue and collective exchange.

Managerial and Administrative

12. The quantity, quality, and measurability of indicators was a challenge throughout the implementation of SP 2008-2013. The assessment in most cases focused on quantitative indicators, with limited qualitative analysis. The improvement over the years in the performance monitoring and assessment of SP 2008-2013 demonstrated the value of conducting comprehensive qualitative analysis to better demonstrate results. However, the process was considered quite burdensome. As a result, the process has been simplified: the number of indicators has been reduced and their quality improved. The indicators in SP 2014-2019 focus on measuring advances toward improved health status in relation to the impact indicators, rather than on the assessment of processes.

13. The performance monitoring and assessment (PMA) process for SP 2008-2013, although it was conducted at the Secretariat level, also covered progress by Member States. The new assessment process will clearly define the different levels of accountability. Impacts and outcomes will be assessed based on official available information systems from Member States, and output and deliverables will be under the

Secretariat's responsibility. The Secretariat has reviewed the PMA, and a new process that combines efficiencies with flexibility for identification of challenges and performance of adjustments has been identified. A process for periodic independent evaluations should also be incorporated to ensure continuous improvement of programming and contribute to accountability, with information made available to all levels of management and to stakeholders.

14. The PAHO SP 2008-2013 was the first plan to be fully implemented using the RBM framework. The implementation of RBM allowed the Organization to better demonstrate results and focus resource allocation, while increasing transparency and accountability. This approach has been institutionalized in PAHO to a significant extent, as reflected in the latest UN Joint Inspection Unit report. PAHO will continue to consolidate its RBM framework in order to enhance transparency and accountability, while simplifying the planning, budgeting, and PMA processes, by increasing capacity building. The new PAHO Management Information System (PMIS) will further enhance the implementation of RBM across PASB. The system will generate and use performance information for accountability, reporting to external stakeholders and providing information to internal management for monitoring, learning, and decision making.

Annex II - *Programmatic Priority Stratification Framework*

1. The Strategic Plan establishes this framework to serve as a key instrument in order to guide the allocation of all available resources to the Pan American Sanitary Bureau, including human and financial resources, and for targeting resource mobilization to implement the PAHO Strategic Plan 2014-2019. This framework is in line with the principles of the PAHO Budget Policy and with the PAHO results-based management framework. Genera principles, including criteria and a scientific method, are set out to guide the application of this framework in an objective manner.

2. This framework builds on the programmatic prioritization process of the PAHO Strategic Plan 2008-2013 and the one used in the WHO draft 12th General Programme of Work 2014-2019.

3. This framework's methodology is in line with PAHO RBM framework and, therefore, should contribute to enhancing accountability and transparency in the allocation and mobilization of resources using a programmatic approach.

4. The criteria and method will be applied across the program areas (approved by Executive Management and the Countries Consultative Group) to identify priority levels (e.g., priority levels 1, 2, and 3).

5. Given that Category 6 (Corporate Services and Enabling Functions) supports the delivery of technical cooperation in Categories 1 thru 5, including country presence, and that it is dependent on the regular budget, it is important to ensure that the necessary funds are available to cover such functions. The level of funding for this category will be determined based on analyses of essential costs, efficiencies, and cost-effective measures, among others (PASB to undertake such analyses). Because the cross-cutting themes in program area 3.3 (gender, equity, human rights, and ethnicity mainstreaming) apply to all categories, the same criteria used for funding the program areas in Category 6 apply to this program area.

6. Taking into consideration that the Organization has already established the program areas, representing the priorities of the SP 14-19, a regular budget floor should be set for each program area. This will ensure a minimum coverage of the Organization to maintain the gains and institutional response capacity. The historic RB expenditure over the last two biennia will be a key input for determining the budget floor by program area (average to be determined by PASB).

7. After the items in paragraphs 5 and 6 have been covered, the allocation of remaining funds will be guided by the priority stratification method and the criteria

defined in this framework. This will be complemented by the criteria established in the resource coordination mechanism, including the outcome indicator gap (the distance between the baseline and the expected target to be achieved by the end of a biennium), based on the costing of the Program and Budgets. Allocation of flexible resources mobilized will be done according to the priority level and programmatic gap. This methodology provides a means to compare different health issues in a relative, not absolute, framework, as equally as possible, and in a somewhat objective manner.

8. The methodology is qualitative in nature, and in this sense it involves individual value judgments used to generate consensus. The results reflect the collective perception of topics, issues, or problems assessed. Therefore, its application benefits from a multidisciplinary approach.

Methodology

9. The proposed methodology is based on the well-known and widely accepted Hanlon Method for health priority setting.

10. The method is based on the following components: *(a)* magnitude, *(b)* seriousness, *(c)* effectiveness, and *(d)* feasibility (see definition below of each component). Weighting is done according to the Hanlon-modified Priority Rating System (PRS) method (APEXPH/NACHO 1991). These four components take into consideration the public sector, particularly the health sector. In addition, the institutional strategic positioning of the Organization is considered as a fifth component, including criteria proposed by Musgrove (1999).

Magnitude of the issue (size of the issue/problem)

(a) Relative contribution to the regional burden of disease or relative importance to the regional health agenda (based on the PAHO Regional Core Health Data and Country Profile Initiative, Health in the Americas 2012, and the Global Burden of Disease Study 2010 main results)
(b) Relative contribution to the global burden of disease or relative importance to the global health agenda (based on the PAHO Regional Core Health Data and Country Profile Initiative, Health in the Americas 2012, and the Global Burden of Disease Study 2010 main results)
(c) Public goods (critical for improving public health and not necessarily attractive to markets)

Seriousness of the issue (severity and urgency of the issue/problem)

(a) Emergent nature of the problem

(b) Burden to the health services

(c) Potential to cause premature mortality and disability

(d) Contribution to global and regional health security

(e) Threat to sustainable human development

(f) Disproportional impact on population groups living in conditions of vulnerability

(g) Threat to universal access to health

(h) Potential economic losses at the individual and community levels

Effectiveness of the interventions for addressing the issue (how well the issue can be solved, if at all)

(a) Availability of cost-effective interventions (includes best practices and best buys)

(b) Potential to work with other sectors, organizations, and stakeholders to have a significant impact on health

(c) Public demands (includes political aspects, public opinion, pressures for public expenditure, among others)

Feasibility of addressing the issue (the PEARL criteria)

(a) Propriety: Does the issue fall within the health sector mandate/responsibility?

(b) Economic feasibility: Does it make economic sense to address the issue; are there economic consequences if the issue is not addressed? (includes proximity to elimination or eradication of a disease or infection)

(c) Acceptability: Will the Member States and/or target population accept the issue being addressed? (includes existence of evidence based knowledge, science, and technology for improving health, and the capacity to apply it)

(d) Resources: Are resources available to address the issue? (includes national institutional capacity, involvement of other agencies/partners addressing the issue, and availability of financial resources from national or external sources)

(e) Legality: Do current laws, regulations, and mandates (at global, regional, and/or national levels) allow the issue to be addressed?

Institutional strategic positioning

(a) PAHO's value-added (includes PAHO's technical cooperation cost-effectiveness to attain the health outcomes defined in PAHO Strategic Plan 2014-2019)

(b) Key for PAHO's governance and leadership

(c) PAHO's ability to contribute to capacity building in Member States

(d) Issue explicitly designated as a priority in PAHO Country Cooperation Strategy (CCS) or national health strategies or plans (or state or provincial strategies or plans in the case of federated countries)

Application

11. A Hanlon-PRS PAHO-adapted Priority Stratification Matrix Tool will be used to assign scores by evaluators in initially independent scoring iterations. Next, an overall score for each programmatic area will be determined by computing the trimmed mean of the individual scores distribution (i.e., excluding minimum and maximum values). The CCG validated the methodology in a pilot exercise conducted jointly with the PASB. The methodology will be applied by Member States as part of the national consultations for the SP 2014-2019. A Priority Stratification Matrix Tool will be used to capture the scores of each Member State. All scores will be integrated to obtain the regional average scores by program areas (trimming extreme values), which will result in the three strata of priorities, as outlined in the methodology above.

12. PAHO/WHO Representative Offices will facilitate the national consultations in joint collaboration with the health authority.

13. The results will be included in the SP 14-19, and its application in the Program and Budget will be submitted for approval by Member States.

Annex III - *List of Countries and Territories and Their Acronyms*

	Country	Acronym
	Member States	**35**
1	Antigua and Barbuda	ANI
2	Argentina	ARG
3	Bahamas	BAH
4	Barbados	BAR
5	Belize	BLZ
6	Bolivia (Plurinational State of)	BOL
7	Brazil	BRA
8	Canada	CAN
9	Chile	CHI
10	Colombia	COL
11	Costa Rica	COR
12	Cuba	CUB
13	Dominica	DOM
14	Dominican Republic	DOR
15	Ecuador	ECU
16	El Salvador	ELS
17	Grenada	GRA
18	Guatemala	GUT
19	Guyana	GUY
20	Haiti	HAI
21	Honduras	HON
22	Jamaica	JAM
23	Mexico	MEX
24	Nicaragua	NIC
25	Panama	PAN
26	Paraguay	PAR
27	Peru	PER
28	Saint Kitts and Nevis	SCN
29	Saint Lucia	SAL
30	Saint Vincent and the Grenadines	SAV
31	Suriname	SUR
32	Trinidad and Tobago	TRT
33	United States of America	USA
34	Uruguay	URU
35	Venezuela (Bolivarian Republic of)	VEN

	Country	Acronym
	Associate Members	**4**
36	Aruba	ARU
37	Curaçao	CUR
38	Puerto Rico	PUR
39	Sint Maarten	DSM
	Participating States	**3**
	France	**3**
40	French Guiana	FRG
41	Guadeloupe	GUA
42	Martinique	MAR
	Kingdom of the Netherlands	**3**
43	Bonaire	BON
44	Saba	SAB
45	Sint Eustatius	STA
	United Kingdom of Great Britain and Northern Ireland	**6**
46	Anguilla	ANU
47	Bermuda	BER
48	British Virgin Islands	BVI
49	Cayman Islands	CAY
50	Montserrat	MON
51	Turks and Caicos	TCA

Annex IV - *PAHO Mandates, Resolutions, Strategies, and Plans of Action*

	Category and Program Area	PAHO Mandates, Resolutions, Strategies, and Plans of Action
1	**Communicable diseases**	
1.1	HIV/AIDS and STIs	Regional Strategic Plan for HIV/AIDS/STIs (2006-2015)
		Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis (2010-2015)
1.2	Tuberculosis	Regional Strategy for Tuberculosis Control (2005-2015)
1.3	Malaria and other vector-borne diseases (including dengue and Chagas)	Strategy and Plan of Action for Malaria (2011-2015)
1.4	Neglected, tropical, and zoonotic diseases	Strategy and Plan of Action for Chagas Disease Prevention, Control and Care
1.5	Vaccine-preventable diseases (including maintenance of polio eradication)	Regional Immunization Vision and Strategy, 2007-2015
		Global Vaccine Action Plan (Resolution WHA65.17)
1.6	Viral hepatitis	Viral Hepatitis (Resolution WHA63.18)
2	**Noncommunicable diseases and risk factors**	
2.1	Noncommunicable diseases and risk factors	Plan of Action on Psychoactive Substance Use and Public Health (2012-2021)
		Plan of Action to Reduce the Harmful Use of Alcohol (2012-2021)
		Regional Strategy and Plan of Action for Cervical Cancer Prevention and Control (2008-2015)
		Regional Strategy and Plan of Action on Integrated Approach to the Prevention and Control of Chronic Diseases Including Diet, Physical Activity and Health (2006-2015)
		WHO Framework Convention on Tobacco Control
2.2	Mental health and substance use disorders	Strategy and Plan of Action on Epilepsy (2011-2021)
		Strategy and Plan of Action on Mental Health (2009-2019)
2.4	Disabilities and rehabilitation	Action Plan for the Prevention of Avoidable Blindness and Visual Impairment (2009-2013)

	Category and Program Area	PAHO Mandates, Resolutions, Strategies, and Plans of Action
2.5	Nutrition	Regional Strategy and Plan of Action on Nutrition in Health and Development (2006-2015)
		Strategy and Plan of Action for the Reduction of Chronic Malnutrition (2010-2015)
3	**Determinants of health and promoting health throughout the life course**	
3.1	Women, maternal, newborn, child, and adolescent health, and sexual and reproductive health	Plan of Action on Adolescent and Youth Health (2010-2018)
		Plan of Action to Accelerate the Reduction of Maternal Mortality and Severe Maternal Morbidity (2012-2017)
		Regional Strategy for Improving Adolescent and Youth Health (2008-2018)
		Regional Strategy and Plan of Action for Neonatal Health within the Continuum of Maternal, Newborn, and Child Care
3.2	Aging and health	Plan of Action on the Health of Older Persons, including Active and Healthy Aging (2009-2018)
3.3	Gender, equity, human rights, and ethnicity mainstreaming	Plan of Action for Implementing the Gender Equality Policy (2009-2013)
3.4	Social determinants of health	Strategy and Plan of Action on Urban Health (2013-2021)
3.5	Health and the environment	Strategy and Plan of Action for the Reduction of Chronic Malnutrition (2010-2015)
		Strategy and Plan of Action on Climate Change (2012-2017)
4	**Health systems**	
4.1	Health governance and financing; national health policies, strategies, and plans	
4.2	People-centered, integrated, quality health services	Regional Policy and Strategy for Ensuring Quality of Health Care, Including Patient Safety (2007-2013)
		Integrated Health Service Delivery Networks: Concepts, Policy Options and a Road Map for Implementation in the Americas (2011)
4.3	Access to medical products and strengthening of regulatory capacity	Access to Medicines
		Strengthening National Regulatory Authorities for Medicines and Biologicals (CD50.R9)

	Category and Program Area	PAHO Mandates, Resolutions, Strategies, and Plans of Action
4.4	Health systems information and evidence	Regional Plan of Action for Strengthening Vital and Health Statistics (2008-2013)
		Strategy for Strengthening Vital and Health Statistics in Countries of the Americas
		Strategy and Plan of Action on eHealth (2012-2017)
4.5	Human resources for health	Toronto Call to Action for a Decade of Human Resources in Health in the Americas
5	**Preparedness, surveillance, and response**	
5.1	Alert and response capacities	International Health Regulations (2005)
5.2	Epidemic- and pandemic-prone diseases	International Health Regulations (2005)
5.3	Emergency risk and crisis management	Plan of Action on Safe Hospitals (2010-2015)
		Safe Hospitals: A Regional Initiative on Disaster-Resilient Health Facilities (2008-2015)
5.4	Food safety	
6	**Corporate services and enabling functions**	
6.1	Leadership and governance	
6.2	Transparency, accountability, and risk management	
6.3	Strategic planning, resource coordination, and reporting	PAHO RBM Framework 2010
6.4	Management and administration	
6.5	Strategic communications	PAHO Knowledge Management and Communication Strategy (2011)

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